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PERCEPTIONS OF PREGNANCY

by

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ABSTRACT

This thesis describes an intensive, longitudinal study of a small group of women who were expecting their first babies, in an attempt to describe what it was like for them to be pregnant. The sample were mainly the wives of manual workers who fell outside the managerial ranks (as defined by the Socio-Economic classifications). The work relies upon detailed analysis of three semi-structured tape-recorded interviews per woman, conducted at different periods of their pregnancy. Through giving an overall picture of first pregnancy, I have tried to highlight the variety of reactions to it, and elucidate the range of experiences and definitions that the women had of the situation.

The underlying theme of the thesis is the problem of uncertainty, and many of the issues discussed are manifestations of this theme. The first part of the analysis looks at the question of identity. This is closely related to the discussion of body image which follows. The women's perceptions of their identity and body image led many of them to feel embarrassed by certain aspects of their obstetric care. The thesis then considers one of the women's central preoccupations : the management of pain during labour. The second part of the analysis begins by discussing their image of babies, and considers how they coped with their children during their early days as mothers. It goes on to suggest that their reactions to motherhood could be expressed as a continuum based predominantly on their images of themselves and their bodies. In conclusion, the women's perception of the meaning of the transition to motherhood is then discussed, and the thesis ends with a summary of some of the implications which the study holds for the maternity services.

DECLARATION

In accordance with Regulation 2.4.15 of the Regulations made by the
Senatus Academicus of the University of Edinburgh under Resolution 14/1967
I now declare that this thesis was entirely my own composition and that
the work which it describes was undertaken by me.

Barbara Ann Moyes.

Barbara Ann Moyes

20 August 1976

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PART I : THE BACKGROUND TO THE STUDY

INTRODUCTION

This thesis is unified on several levels. Firstly, it is unified on the simple level of chronology. The order of the chapters broadly follows the course of pregnancy in that it moves overall from a consideration of pregnancy to motherhood, and in that issues are generally dealt with as they emerge in importance.

Secondly, the assumptions and beliefs which the women held about their transition to motherhood underlie the thesis and help tie it together. These were important because, in the face of uncertainty, the women had to fall back upon what for them passed as knowledge and use this as the basis for their behaviour. For example, one central assumption was that they must always maintain face. Much of their behaviour should be understood in terms of this assumption, but it was particularly important during their obstetric care (face must be maintained by not giving in to embarrassment), the birth (face must be maintained by not succumbing to the pain and shouting and screaming), and as new mothers (face must be maintained by ensuring that the baby is always kept under control).

In order to supplement what passed as knowledge, throughout the process the women relied on cues to help them work out how to act. Examples of their cue-taking behaviour are to be found throughout the thesis.

Thirdly, the thesis is organized around several broad themes (or problems) which emerged as central to the women's experience of pregnancy. The main themes are uncertainty, identity, body image and embarrassment. Uncertainty is the basic underlying theme and it recurs throughout the thesis in various forms. All these themes, although presented singly, are inter-related. A brief consideration of some of the ramifications of identity will provide an example of how one theme relates to several others and welds the thesis into an integrated whole. On one level identity is one of the manifestations of uncertainty. Then, the desexualization process,

which is part of the problem of identity, and which is largely built on the women's body image, is a crucial element in the understanding of embarrassment. Like the question of embarrassment, the problem of the management of pain is also concerned with maintaining face (or the most desirable identity). The women's perception of their identity, or self image, emerges again as one of the most influential variables in determining how they react to motherhood, and changes in identity are also important in a consideration of what the transition means to them. Other themes are equally pervasive, but in particular Chapters 5, 6 and 7 (identity, body image and embarrassment) have such interrelated themes that these chapters must be read together, as an understanding of one aspect often depends upon the understanding of another. Similarly, Chapter 10, which describes how the women cope with their baby, is partly based on an understanding of the images they had of their babies, which are discussed in Chapter 9. Many of these themes also form the background to Chapter Eleven, where they are shown to have a significant influence upon how a woman reacts to motherhood.

And finally, the thesis is unified on another level. As well as discussing the problems which faced the women, it also goes on in each instance to consider how they coped with their difficulties.

The fact that my thesis forms such an integrated whole lends weight to my conviction, discussed in the next chapter, that it is essential to look at the process of pregnancy as a whole, rather than in isolated fragments, if we are ever to understand it.

CHAPTER ONE: THE LITERATURE

This chapter describes some of the work which has already been done on pregnancy, and concludes by showing the need for an intensive study of the process of pregnancy as a whole. Whilst there is a considerable body of medical and psychological literature, little work seems to have been done from a sociological perspective. This chapter begins by briefly outlining the medical background to pregnancy. The second section discusses the more central psychological and sociological contributions. It considers the nature of the transition to motherhood, and culminates in a criticism of past research. By the end of the chapter the need for a small-scale, longitudinal study should be clear.

Medical Background

The medical outcome of pregnancy is the combined result of social and biological factors. For example, it is widely acknowledged that women of low socio-economic status have higher rates of perinatal, neonatal and post-natal mortality (1). Smith (2) emphasizes that the mother's social class accounts for a larger part of the variance in perinatal mortality than any other identifiable attribute of pregnancy or delivery. These differentials have remained virtually unchanged since 1911 so that whereas the overall death rates have fallen dramatically, the relative positions of the social classes are unchanged (3). Although our knowledge of complications of pregnancy is admittedly limited, Illsley (4) has suggested that the various complications (still births, neonatal deaths, congenital malformation of the central nervous system, low birth weight, difficulty of labour) are all influenced by the socio-economic status of the parents. Butler and Bonham (5) have said that mature pregnancies (forty weeks) are most common in Social Class I but least common in Social Class V. When even a slight variation from term is considered dangerous, ^{in terms of infant loss} this is significant. However,

some difficulties of labour (for example, long labour, forceps delivery and Caesarean section) are greater for women of higher socio-economic class. Illsley (4) and Baird (1) equate this with the fact that these women are generally older when they have their babies. They tend to have longer labours, for instance, as a result of disordered uterine action and the inability to bear down effectively in the second stage.

Obstetric care has a part to play in reducing perinatal mortality, but unfortunately attempts to evaluate its quantity and quality have remained elementary and unsophisticated. This is partly because of the difficulty in formulating an adequate measure, and partly because such research has been general and impressionistic, tending to discuss one area of care in isolation and failing to see that the issues of, for example, ante-natal care and hospital confinement form a complexly interrelated whole (6), (7). In addition, some of these studies have been written by doctors from their personal experience, with the result that it is difficult to tell how representative their results are. A further important shortcoming is that most studies completely fail to see the situation from the patient's point of view. However, despite the quality of available research, Smith (7) concludes that although ante-natal care is still a rather rudimentary branch of medicine, nevertheless there are advantages to the foetus who has early access to ante-natal care (8).

But not every woman gives her foetus early access. It seems to be lower working class women who particularly underutilize the services (9). In an attempt to delineate their characteristics McKinlay examined the utilization behaviour of a group of these women in Aberdeen (10). He found that utilizers tended to be "go-getters." They were able to plan and to determine their own behaviour, and consequently overall exhibited a pattern of security. For example, their babies were

legitimate, their husbands in work and doing over-time, and their housing was secure. In contrast, the underutilizers' life style was characterized by instability. They were often dependent upon a succession of relatives until they obtained a council house. Their husbands tended to be sick or unemployed, and their marriages often took place after their first child had been conceived. McKinlay concluded that the main distinguishing variable between the two groups was the legal status of their first pregnancy. There was also one other important variable. McKinlay suggested that the women who underutilized the services had interlocking kin and friendship networks, and displayed a higher frequency of interaction with relatives than with friends. Utilizers, however, seemed to have separate kinship and friendship networks, and gave the friendship network preference.

In sum, social and biological factors both seem important in determining the outcome of pregnancy, but broadly speaking it seems that the lower the class, the higher the mortality rate. Early access to medical care is recognized as being of benefit to the foetus, but attempts to evaluate obstetric care have been flawed. Some work has been done on the utilization of services, and McKinlay has described some of the contrasts between women who use the services and those who do not.

The Psychological Contribution

Freud, impressed by the emotional calmness of pregnant women, considered pregnancy as a time when women live in bliss of their basic wish being gratified^(10g). Since Freud there have been a number of rather different approaches to the subject. More recently pregnancy has been seen as a crisis. However, the exact nature of the crisis has been disputed. Some researchers have understood it as basically a normal event and, indeed, a crucial part of growth which must precede and prepare maturational integration^(15,16). Others have regarded it largely as a "disturbance in the neurotic woman," and have implied that "healthy women

do not pass through such a crisis."^(10c)

Those who see pregnancy as a developmental crisis (11) have been able to build on Erikson's work (12). But as Bibring points out, puberty, pregnancy and the menopause, although having things in common with Erikson's significant principal steps in human growth also form a different group because they involve biological changes (13). It is precisely these biological changes which lend them their quality of the inevitable. In the sense that once a mother, always a mother, they are points of no return. This biological element has loomed large in Benedek's interpretation of pregnancy as a psychosomatic condition which is determined by corpus luteum and progesterone. Benedek argues that it is the heightened hormonal and metabolic process which leads to the narcissistic state during pregnancy (14).

Bibring has lent influential support to the idea of pregnancy as a normal crisis (15). She describes the transition to motherhood in terms of the woman's relationship to her sexual partner, her self and her child. She believes that the early phase is one of enhanced narcissism. Then quickening introduces the baby as the new object within the self. The mother's final relationship to her child will be a fusion of narcissistic and object-libidinal strivings, so that the child will always remain part of her, whilst also being an object that is part of the outside world and her partner. Bibring's study showed that the maturational integration occurred gradually, and carried on after delivery.

Caplan (16) is another of the 'normal crisis' school. Concentrating on the emotional changes which occur during pregnancy, he suggests that pregnancy heralds a change in the equilibrium between the ego and the id, with the result that women talk more freely about their earlier, hitherto unconscious needs, wishes and fantasies and, with the help of their adult capabilities are often able to find solutions to their problems.

Psychoanalytic literature on female sexuality has implicitly or

explicitly regarded pregnancy as a state of crisis. Deutsch (17), in particular, has looked at pregnancy and motherhood as part of her interpretation of woman's life-cycle and has elucidated some of the deeper conflicts and fantasies of pregnancy. More recently, de Beauvoir and Raynor have also discussed pregnancy in terms of woman's developing life-cycle and role (18), (19), whilst Newton has argued that a woman's attitude to pregnancy and childbirth should be understood in relationship to her attitude to her wider sexual role (20). Breen has postulated a relationship between pregnancy and birth and a woman's sense of femininity. She found that it was the ill-adjusted rather than the well-adjusted women who showed a higher femininity score once they had become mothers (21).

Following on from the work of the psychoanalytic school, much psychological research has concentrated on the emotions of pregnancy. Probably the first study of this kind was conducted by Hamilton (22). The field has been usefully reviewed by Newton (23). Some of the more important areas here have been the acceptance/rejection of pregnancy, fears and anxieties during pregnancy and the origins and effects of mood swings. A large percentage of women are said to reject their pregnancy at the time of conception, but adapt to it over the nine months (24). However, Pohlman (25) suggests that adapting to pregnancy may be a 'courtesy' or 'obligation' to maintain self-esteem, and may hide the fact that the pregnancy is still not seen as desirable. Women expecting their first babies tend to be happier and more accepting than those expecting subsequent children.

Fears and anxieties tend to increase during pregnancy and decrease after delivery (26), reaching a peak during the last half of the last trimester (27). The content of these fears seems to range widely (28); perhaps folk-lore influences women, particularly the less well-educated, more than is generally realized (23).

Mood swings appear to be uniquely human - the chimpanzee, one of our nearest neighbours, does not experience similar swings (29). Mood

swings may be a result of hormonal factors(14),or of the shifting ego-id relationship during pregnancy (15),(16). There is now no doubt that physiological stress can influence the foetal environment,the foetus and its birth (30).

As yet,however,there is no evidence of a causal relationship between physiological and psychological disturbances (30). In conclusion,pregnancy is now commonly understood as a crisis. The psychoanalytic school has tended to see pregnancy in the wider context of a woman's maturation or role,whilst much psychological research has concentrated on examining the emotions of pregnancy. Some of the more interesting work here has discussed the repercussions a woman's emotional state might have for her baby.

The Sociological Contribution.

Van Gennep first employed the phrase rite de passage in sociology and showed the importance of this phenomenon (32). He showed that preliterate societies offered clear and widely accepted roles and procedures to guide people through each transition. Realizing that life in any society is a series of transitions,he described how preindustrial societies enveloped their transitions in ceremonies whose purpose was to enable people to pass from one defined position to another which was equally well defined. In this way rites de passage cushioned any disturbance people might feel in undergoing such a change. In many of the societies van Gennep described,the rites of pregnancy and childbirth began with some form of separation rite. That is,the woman was separated from her society,her family group and sometimes from her sex either because she was considered impure and dangerous,or because her pregnancy placed her physiologically and socially in an abnormal position. It was often seen as natural that she should be

treated as if she were ill or a stranger. A second set of rites referred to pregnancy itself, and included several ceremonies whose purpose was to facilitate the delivery and safeguard the mother and child. These were usually followed by the rites of childbirth which gradually re-integrated the woman into her former group or established her new position in society as a mother. (In addition to this, a first birth usually carried a considerable social impact which was variously expressed among different people.) Then, if the mother was regarded as impure after giving birth, then generally so was her child. Therefore the child also underwent ceremonies of separation, transition and incorporation. A popular way of expressing separation was by cutting the umbilical cord, whilst the rites of incorporation could include naming, ritual nursing and baptism.

Fortes (33) summed up van Gennep's three significant theorems as follows: (a) that critical stages of the life cycle, though tied to physiological events, are socially defined, (b) that entry into and exit out of these critical stages are always marked by ritual and ceremony in primitive societies AND Christian societies and ancient civilizations, and (c) that these rites follow a more or less standard pattern. Fortes expanded van Gennep's analysis by asking why ritual is necessary. In answer, he argued that societies distinguish between the individual and his statuses or roles. It is because the individual is more than his status or role that ritual is needed in order to confer them upon him or take them away. Ritual mobilizes authority behind the granting of status and thereby guarantees its legitimacy and imposes accountability for its proper exercise. It therefore becomes the means by which an individual is divested of his former status and invested with his new status.

As Kimball said (32), there has been no evidence that the secularized, industrial world has lessened the need for ritualized expression of

status passage. The critical problems posed by status passages are directly related to the devices which society offers its members to help them achieve a new adjustment. But modern societies offer few such devices, and this may be one of the reasons why, as Rapoport and Rapoport (34) have shown, transitions in industrial societies seem to involve even more uncertainty than they did in preliterate societies. Kimball suggested that one dimension of mental illness may arise because more and more people are being forced to accomplish these transitions alone.

In the light of this marked absence of ritual, the significance of Rossi's work (35) on the transition to parenthood becomes more apparent. Basically, she asked what this transition involves today. Preferring to follow Erikson and understand pregnancy as a developmental stage rather than a normal crisis, Rossi intuitively felt that the major transition point for women is not marriage, but the birth of the first child. She argued that parenthood requires much more adjustment and learning than marriage. This is partly because a wife already knows her husband and so is able to make preparatory adjustments before they marry, but she does not know the baby, which means that a lot of fantasy can evolve which can make the eventual adjustment much more difficult. Another reason is that the new mother has probably not had much preparation for her role. The transition to parenthood is also very final and abrupt, and it is exacerbated by our system of isolated nuclear families. In addition, the lack of any accepted guidelines as to how to be a good parent and rear a successful child only serves to make the situation more bewildering to the new mother. Rossi asks some pertinent questions, but they do not seem to have received an entirely satisfactory answer. Some work has been done on the crisis nature of the transition to parenthood (which has been reviewed by Jacoby (36)), but it has tended to focus on only a small part of the wide subject Rossi was broaching. However, it has been shown that

working-class wives in London were "psychologically unprepared" for motherhood, despite their willingness to accept the role in theory (37). This was at least partly because their expectations of motherhood seemed to be gleaned from the old patterns of extended family street life, but what they actually found on becoming mothers were isolation, loneliness and reduced contacts with their extended families. There seems to have been little sociological analysis of the transition to motherhood which sees pregnancy as a whole process and looks at it from the mother's point of view. Indeed, Anwar (38) makes the point that the woman's perspective has been virtually ignored in studies of pregnancy behaviour, except perhaps for the work done on the sick role. There seem to be only two studies of any importance, one by Hubert and one by Anwar.

In a stimulating but brief article based on her study of working-class primiparae in London, Hubert argued that the mother's ideas and beliefs and her whole attitude to conception, pregnancy and birth affect the early relationship between the mother and child (39). She showed that these ideas and beliefs did not correspond to the 'scientific' view, and were not even consistent within one social class. Like Gavron, (37) she found that the women were unprepared for their lives as pregnant women and mothers. They knew little about birth control or the whole process of conception and reproduction. This state of ignorance, or at best, indifference, set the tone for the 'muddling through' which seemed to characterize most of their behaviour during pregnancy and early motherhood. Hubert found, as I did, that throughout pregnancy there was uncertainty as to which symptoms were normal. She felt that this was partly a result of the unintentional lack of rapport between the medical staff, with their 'scientific' perspective, and the women, with their collection of individual attitudes and beliefs. These women were also ill-prepared for labour. Most of them approached it happily, expecting it to be straightforward, and were shocked when they found it

lonely, bewildering and frightening. (This was one of the biggest areas of difference between Hubert's work and mine.) Hubert felt that if the women had had more sense of what was happening to them physiologically, they would have been more able to understand what they were experiencing. Even the girls who attended the Classes remained largely ignorant as the Classes assumed too high a level of knowledge and sophistication. Like several of my women, they found it difficult to visualize themselves as mothers or to formulate any realistic picture of the baby. Instead, they tended to think of it as an object or new possession rather than a separate person. Because of this, they were often taken aback at the arrival of a hungry, demanding baby, and found initial difficulties in coping as mothers. Hubert's study has definite parallels with my own here, and all in all it provides an interesting comparison with my work.

Anwar's Canadian comparison of middle-class married and unmarried mothers was an attempt to discover the meanings and definitions the women used during pregnancy, and to assess the influence of the interactive network upon the way they coped. Her main finding seemed to be that women who conceived after marriage were characterized by extensive utilization of lay resources and early and consistent medical care. They dealt with pregnancy routinely and without much extraordinary effort. However, this was not true of the unmarried girls. They did not use regular medical facilities and felt highly stigmatized. The most significant factor in determining how a married woman would cope was the time of her conception in relationship to her marriage. In crude terms, it seemed that the earlier her marriage, the better able she was to cope.

Thus the transition to motherhood has come to be acknowledged as an important status passage, but one which in modern society lacks any clear guidelines or ritualized expression. The following section criticizes the existing literature and places my work in context.

Criticism of the Literature.

Much research has been marred by poor methodology. For example, some of the more psychiatric-based work consists of psychiatrists or social workers generalizing from their patients⁽⁴⁰⁾. There are two problems here. Firstly, as they are not necessarily imposing a rigorous methodological framework on their studies, the work is open to considerable bias; and secondly, as it is often unclear how typical the sample is, it is hard to tell how general the conclusions are. Several studies have been retrospective^(35, 41) and these run the obvious danger of faulty and inadequate recall. There is also a related problem which could be called the problem of redefinition. Those studies where the subjects are seen only once⁽³⁶⁾ ignore the fact that pregnancy is a process during which ideas and attitudes change and evolve. Instead of reflecting the development of the women's reactions and adjustments to pregnancy, they merely present a static picture of attitudes caught at one time. The subtleties of the definitions and redefinitions which are made are therefore lost.

Other research has concentrated solely upon one aspect of pregnancy (for example, the sick role⁽⁴²⁾, utilization of services^(9, 10), parental satisfaction⁽³⁷⁾.) This may have been unavoidable given the resources available, and these studies have produced some valuable information. However, it seems more helpful to look at pregnancy as a whole because, as my work shows, the issues involved are all interrelated. It is therefore difficult to make sense of one issue independently of another.

In contrast, the psychoanalytical and developmental literature^(17, 18, 19) does describe pregnancy as a whole, often placing it in the context of a woman's life-cycle. It has offered some illuminating insights into a woman's psychological experience of pregnancy, but perhaps these very features are its shortcomings.

It makes little attempt to see the woman in her social context, and in discussing the impersonal or 'universal' woman it tends implicitly to assume a middle-class standpoint. The emphasis on a woman's psychological development also tends to ignore her experience of the everyday happenings of pregnancy. Some of this work simply reflects people's thinking and reading about the subject. This approach has its uses, but we undoubtedly also need empirical studies in order to discover how far these impressions are reflected in the experience of ordinary women.

Sometimes the analysis seems superficial. This may be a result of the methodology. The fact that Anwar, for example, had to admit that she was unable to say much about her women's meanings and definitions of pregnancy could well be because she only saw them once and this was not long enough for them to build up the sort of relationship where they felt able to reveal their innermost feelings.

However, I believe Anwar was right in her basic premise that we should concentrate on definitions and meanings. It is precisely because the perceptions of the women undergoing the transition have been neglected that outsiders are now delineating the problems, crises and expectations. This is surely not conducive towards offering an optimal service.

Only when we understand how the women themselves react to pregnancy can we begin to develop our services in response to their real needs. Morris (6) saw this when he wrote: "Doctors, nurses and aides should understand and come to know pregnancy, labour and delivery as a continuing process, rather than in bits and pieces, a series of techniques. They need to understand it and see it from the mother's view-point, as well as in terms of bottles, diapers, rooms, instruments and procedures."

Therefore, following on from the work of van Gennep and Rossi and elements from using the sociological framework of the rite de passage, I have examined how a group of 'normal' women perceived their first pregnancy. The methods I used are described in the next chapter.

CHAPTER TWO: THE METHODOLOGY.

Like Bott (1), I began my work with no well-defined hypotheses. At first I merely knew I wanted to look at what effect pregnancy and the first birth have on ordinary women today. As this would clearly be an exploratory piece of work, I decided to make an intensive study of a small group of women rather than a survey of many women. The most appropriate methodology seemed to be a longitudinal study based on fairly informal semi-structured interviews relying on open-ended questions (2). My aim was to provide a description and explanation of the attitudes and behaviour of a small group of women who were expecting their first baby.

The Women.

There were certain criteria which the women had to meet. These are described in the next chapter. In addition to the main sample, I also interviewed three multiparous women, as I felt that their reactions to pregnancy might sharpen my understanding of the primiparae's experience.

Preparatory Work.

In order to help me define some of the important areas, I conducted a pilot study. With the help of a local G.P., I obtained permission to speak to some of the pregnant women and new mothers who used a Health Clinic in one of the post-war Council estates. I learnt several things from this. I found that the quality of the material was far higher if the interview took place in the woman's home rather than in the Clinic, but that despite the Clinic setting, there seemed to be little difficulty in persuading the women to talk. And, most importantly, after listening to them, I was even more convinced that the birth of the first child was a major transition point in women's lives today. The pilot work gave me some valuable insights. It was then that the problems of self-image, body image and uncertainty were first raised, and my attention caught by the key words, 'embarrassment,' 'routine,' and 'responsibility' - with the result that when I began the inter-

viewing proper, I was immediately able to recognize them as important and explore their significance.

Recruiting the Sample.

There were two obvious ways of recruiting the sample: through the hospital ante-natal Clinics or through the General Practitioner. I decided against the Clinics because it was extremely doubtful that I would have gained access to any of them. Even had I managed to do so, there would have undoubtedly have been a long delay in obtaining permission, and this could have been fatal given my three year time constraint. There were positive advantages in using the G.P.s: they represented the earliest pick-up point (important in a longitudinal study), and they offered a more random group of women in that any patients the Clinics gave me would have been a self-selected group of maternity service 'users.' This was an important consideration in so far as one of the issues I was interested in was the women's perceptions of the maternity services.

In order to select the G.P.s I studied the census data on the city and found out which areas were predominantly inhabited by people from social classes III, IV and V. I then contacted doctors in these areas. Professor Spencer wrote to each doctor introducing me, and I included a brief outline of my study together with a description of how they could help me. I followed this up with a telephone call when I asked if I could see them about the study. I eventually contacted twenty four G.P.s. Only three of them refused to help: one because he felt his practice was not used by my type of women; one because his practice was already so involved in research projects that he did not feel that it could absorb another, and the third because he had virtually no ante-natal cases.

I provided the doctors with introductory letters and pre-paid post-cards for the women to let me know if they would take part, but the Local Medical Committee had been very keen that I left the actual referral system to the individual doctor. I found that the most

successful method was for the doctor to see the woman personally and describe the work, underline support for it and then, if the woman were agreeable, let me have her name and address immediately.

Drop out rate.

I was referred thirty nine women in all. Of these, thirty five agreed to participate. That meant that four dropped out before I met them, making an initial drop out rate of 10.2%. However, it is by no means certain that all four women would have been suitable respondents. Some doctors were lax about the criteria with the result that six of the women I saw were patently unsuitable.

Five dropped out after I had met them. Three of them never began the interviews, either through forgetfulness, apprehension about the study or fear of pregnancy. Sheila (3) and Sue dropped out during the interviewing. Sheila's baby was still born after I had seen her twice. I think that Sue saw me not so much as a researcher but as someone who might be able to help her get a Council house. Consequently, when she was eventually allocated one after my first visit, my visits became superfluous to her and she stopped seeing me.

Perhaps this can be more clearly expressed in tabular form:-

(A)	Number of women contacted	39
(B)	Women who agreed to participate but were found to be unsuitable	6
(C)	Referred, but refused to see me	4
(D)	Dropped out after I had met them	5
(E)	Total number of refusals and drop-outs	9
(F)	Total number interviewed (A-B-E)	24
(G)	Total number of primiparae	22
(H)	Refusal and drop-out rate $\left\{ \frac{E}{(A-B)} \times 100 \right\}$	27%

Preliminary Meeting.

I thought it was important to have a preliminary meeting when the women could see me and find out a little more about what I was asking them to do. I tried to explain why I was doing the study (4) - that little was

known about women's reactions to pregnancy, and that I thought it would be helpful for medical staff to have a clear picture of how women experience pregnancy. I emphasized that I was not there to tell them what to do, or to say whether they were right or wrong. Instead, I was there to learn from them. At first I assumed that they would see my work very much as a survey made up of closed questions, and so in order to try and ensure that they would talk freely, I began by saying that I would not talk much during the interviews - instead I was there to listen to what they wanted to tell me. However, I soon found that this worried them, and so I began to add that there would, of course, be certain areas that I would be asking them about in easy, general terms. This approach seemed far more successful. Throughout this meeting I tried to present the interviews as being like a conversation, and as not being anything very 'academic' or difficult.

It is well known that the way the interviewer presents himself can have a crucial effect on the respondent (5). At this first meeting it was important to establish a self which would be appropriate throughout the research. In general I tried to maintain a stance of equality and neutrality. I felt I must be seen as non-threatening, otherwise some of the women would have lacked the courage to speak freely to me. One way in which I tried to achieve this was by appearing interested in and concerned about the women as people (6). Linked to this non-threatening persona was my part as a novice (they knew that I was married but as yet had no children). The women could therefore feel both superior (in knowing that they were going through a status passage which I had yet to begin), and safe (in the knowledge that I therefore lacked standards by which I could judge them.) During several of these meetings the women began telling me very relevant things. Jean, for example, provided me with an extremely graphic account of her visit to the Booking Clinic. I tried to use this information as a guideline when I began the interviewing proper.

The interviews.

I saw the women three times - at four months, eight months and two months post-partum. Pregnancy is generally divided into tri-mesters, and so seeing the women during their second and third trimesters gave me a fairly comprehensive picture of their reactions. It seemed reasonable to use the two months post-partum as the end of the transition. The women themselves tended to see it as ending with their post-natal examination at six weeks, and so by seeing them at eight weeks I was giving them time to have had this examination and to have got over it.

The interviews varied in length from an hour to all day; they averaged about two and a half hours. I gave the women the choice of being interviewed in their home or mine, and they always chose theirs. The interviews were tape-recorded (7) as I believed that an inductive study required a record of everything that was said. The tape-recorder is also a popular aid for reducing bias. In addition it allowed the interviews to resemble conversations; they could range over a wide area without a note-pad to remind the women that they were being interviewed. However, tape-recording also entailed disadvantages. Firstly, I had difficulty in finding a reliable machine, and secondly it involved me in pages of transcription. I began the interviewing (and necessarily the transcription) in June 1973. I finished the transcription in December 1974. As well as proving so frustratingly time-consuming, this method indirectly impaired the quality of the third interviews. By the time I was conducting the third interviews I had a backlog of second interviews still to transcribe which prevented me from writing up many of the third ones. This meant that as I was unable to become fully familiar with the material and pick out all the salient points at the time, I lost the opportunity of developing these lines of thought further in subsequent interviews. As Bott has put it, the increased field experience which helps the researcher formulate problems and seek

new information was therefore partially lost at this stage (8). However, despite this, I felt that the tape-recorder was invaluable as a means of obtaining rich data.

I conducted all the interviews myself (5),(9). This had two advantages: I was better able to use subsequent interviews to find information which my transcription showed me I lacked, and I was able to avoid the possible bias caused by using several interviewers with different expectations and perceptions.

I chose to interview women rather than married couples because I was primarily interested in the women's perceptions of pregnancy. I also felt that it would take too long to persuade enough husbands to take part - I think many men would have reacted like Ruth's husband and defined the interviews exclusively as "women's talk" and therefore would have refused to participate. I found that the husband's presence could also seriously inhibit his wife. Kathleen, for example, became self-conscious and tongue-tied when, during her first interview, her husband wandered into the room.

Semi-structured interviews and open-ended questions seemed the obvious methodology to adopt (10). Becker and Geer (11) have shown the advantages of using a fairly free interview format as a way of eliciting facts "whose existence (the researcher) had not previously considered orhypotheses he had not formulated when he began his study."

They add, "a respondent in an unstructured interview is more likely to provoke a discovery by saying something unexpected than is the respondent who can only check one of six precoded replies to a questionnaire item." They also point out that a flexible technique is particularly appropriate where the researcher begins, as I did, with many gaps in his knowledge.

The Relationship between the Women and Myself:

(i) Equality and Neutrality.

Benney and Hughes (12) have discussed the importance of establishing

equality in the interview. The fact that I was the same sex and age as the women was helpful here, as it has been shown that "the least inhibited communication seems to take place between young people of the same sex" (13). I tried to establish equality by emphasizing our similarities (I took care to dress, for example, in a similar fashion to their own); and by making light of possible differences (for instance, when Pat, listening to a conversation between her husband and me, remarked that it was "nice for him to have some intelligent conversation," I replied, "But he's got you?" and deflected the subject.) I also tried to be uncritically accepting of whatever happened. (I therefore tried hard to suppress any signs of surprise when Pamela's husband, at our first meeting, entered the room, and without a word, proceeded to lay full-length on the floor with his head against the wall - in order to dry his hair at the air vents as I later realized.)

There seems to be a link between equality and the respondents' perception of the researcher as a non-threatening figure. I tried to render myself less potentially threatening by being self-deprecating (by telling them I was inept with anything mechanical, for example), or by emphasizing my identity as a novice (14). The novice stance was extremely useful in that it combined equality with neutrality. The women showed their awareness of me as another woman and a novice when they made such comments as:

"Wait till you have your own, you'll ken!"

"Oh, what a shame, you'll be put off after all this."

"You're going to know ALL ABOUT it in a couple of years!"

"The Health Visitors dinna ken anything. They're only like yourself."

The other important way by which I tried to preserve neutrality was by taking care to agree with the women, whatever my own opinions (6).

(ii) How I think the Women saw me.

The women assigned me other selves besides those of novice and female contemporary. Jean, for instance, initially saw me as an authority figure;

feeling guilty at refusing to attend the Relaxation Classes, and knowing that I had contacted her through her G.P., she originally believed that I must have come from the hospital in order to make her attend them. The young girls in particular saw me as someone who could tell them about pregnancy and current hospital practice, whilst other women were keen for me to offer them norms so that they could gauge how typical their experiences were (15). Occasionally some of them made explicit reference to my role as researcher as when Kathleen, regretting describing her labour to me in such off-putting detail rationalized it by adding, "But I HAVE to tell you." But mostly they seemed to regard me as a friend (16). Anna told me that she suspected that I just called in "for a wee blether," and others said they would miss my visits when I stopped calling. As the interviews went on they became much more relaxed and far longer - an index, perhaps, to use Hargreaves' term, of increasing cordiality (17).

(iii) The Women's Credibility.

There were several reasons why I believed the women were being truthful. Firstly, they were describing things which were happening to them in the present and very recent past. And, as pregnancy was a new and usually fairly important experience to them, they were more likely to remember and recount experiences accurately than if they had been describing some ordinary, insignificant event. Secondly, they had no real reason to lie. There was no obvious advantage in presenting any particular face; I had always stressed that the interviews were not a test but rather an opportunity for them to enlighten me. Jean clearly saw the interviews in this way. When they were finished she said, "Well, I told you I'd tell you exactly what it was like and I have done. Now, are you going to have one?"

There was a high degree of consistency between different women's accounts (see for example their descriptions of the Bobbing Clinic.) There was equally a high degree of internal consistency between each woman's statements over time (18.)

They volunteered a lot of information. Becker and Geer (41) have shown how much more reliable voluntary statements are than directed ones. I also felt that the type of material I got was indicative of the women's credibility. They were able to talk freely of intimate and sometimes seemingly trivial incidents, as when Anna described in detail how she had been "chatted up" by a "pervert!"

And finally there was some evidence that they found me easy to talk to. For example, Pat, in describing her Health Visitor, said, "She's just like yourself. You can sit and speak to her."

The Exploitative Nature of Interviews.

Weiss (4) felt strongly that eliciting information from people and giving them nothing in return was exploitation. I tried to give general reassurance to girls like Brenda who were terrified of the prospect of birth; sympathy to Pamela in her fight with her selfish employer, and friendship to all those women who felt lonely or bored. I also gave each woman a small thankyou gift when I saw her for the last time.

Analysis of the Data.

During the fieldwork I began to identify some of the main perspectives (11) - for example, identity, body image and uncertainty. By the end of the fieldwork I was able to break them down into their constituent parts and use each part as a page-heading. I then read through all the interviews, woman by woman, recording each episode or comment under the relevant heading. By the time I had finished I had the bare bones of each chapter.

By keeping "the logical structure of quantitative research" (19) in mind, it was less likely that my interpretation would be based on intuitive impressions. By using this method I could easily see the frequency of a particular attitude or feeling, and also take into account the negative cases of any proposition I was using the data to establish (20).

Sociological Approach: Influences on my Thinking

The way I approached this study was influenced by sociologists such as Goffman and Berger and the symbolic interactionist school. This was probably a direct result of my background. For example, I had already firmly adopted what might be called a microscopic approach during my study of English Literature. That is, in order to interpret a text, I would focus primarily upon the meanings of individual key words, and base my interpretation of the work as a whole upon an analysis of their meanings and the meanings of their inter-relationships. Tony Tanner and David Lodge have used this approach and I found their work stimulating. My predilection for concentrating upon the nuances of words was further encouraged by my subsequent employment as a social worker, when I found that I had to develop the skill of listening to what people were 'really saying', and of interpreting their possible hidden meanings. Given this background, it was perhaps inevitable that I should choose a small scale intensive methodology and that I should be influenced by writers like Goffman and Berger. Once I began my study my approach was further sharpened and rounded out by conversations with Michael Anderson, Kathryn Backett and Gill Michael.

My approach held several advantages for the kind of problem I was tackling. For example, my background helped me look at pregnancy from different stand-points and to avoid being hidebound by one perspective. Furthermore, my approach was particularly suitable for an inductive study because such a study relies upon listening hard to what people are saying in order to pick out and develop the meanings behind their words. It was also appropriate given the subject I was studying as it enabled me to elicit and interpret intimate information. And finally, a small scale study was a realistic methodology to use given my three year time constraint.

Evaluation of Method.

All methods have flaws, and so the most appropriate method becomes the one which best answers the particular needs of the study.

Both a large-scale statistical survey and a participant observation study seemed unsuitable for my type of work. A statistical survey used to be thought to have the advantage of being value-free; Easthope (21) has disposed of that myth. Such a survey would not have given me the indepth information I needed. In an exploratory piece of work the interviewer is at pains not to impose his own framework on his respondents, but to let them tell him what they think are the important issues (22). Quantitative data essentially offers a snapshot picture; it is therefore not the best medium for describing change over time.

A participant observation study would have been difficult to conduct in modern urban society as primiparae do not form a distinct group (23).

And, to do the study properly, I would have had to have become pregnant.

Living with a group of families was not ideal either as couples would probably have been reluctant to allow such "constant observation". Even if I had been lucky enough to have been accepted, this method would have demanded far more time than I had at my disposal.

A study which sets out to describe and explain behaviour requires detailed information and a high degree of validity. Focused interviewing is acknowledged as one of the ways of achieving both these requirements (24). Therefore, an intensive, longitudinal study (25) which showed change over time, based on semi-structured interviews seemed the most appropriate method for my purposes.

CHAPTER THREE: THE WOMEN

The purpose of this chapter is to describe the women so that it is clear to which group of people the research refers.

As I was neither conducting a statistical survey nor intending to make generalizations about a wide population, a rigorous class control was not necessary. As Bott (1) has said: "Intensive comparative study of a small number of groups requires a different method from that of surveys and leads to different results. In the present research no attempt is made to produce general factual statements about a wide population of families by studying a sample..... But an attempt is made to develop hypotheses of general relevance. The research families were studied as examples of urban families, not as a random or representative sample." Bell echoed this when, in discussing the television programme, "The Family," (B.B.C.2, 12/10/74), he said that it was irrelevant whether the family in the series was statistically typical; the crucial factor was that this family was confronting a social situation which was common to millions.

I broadly accept Bott's stance. As our aims were similar, I have largely adopted her methodology, with one significant exception. Bott saw people from all walks of life. However, I felt that at least in some areas of my field, over a broad range of social class, class might well be a variable. (I was convinced, for example, that a woman's relationship with her doctor was affected by her social class (2).) On the other hand, I felt that class would not be such a crucial factor when two adjacent classes (for example, III and IV) were being considered. Because of my time constraint I was unable to test this in pilot work, but as a precaution I decided to restrict my women to a fairly homogeneous group. I wanted to focus on women from the middle ranges of society. Therefore the women had to be typical of those middle ranges in so far as what was important or difficult to them as

a group should be important or difficult to their social group as a whole - although as the work did not have a statistical basis, the relative importance my women assigned to each area need not apply to their social group as a whole. The women therefore had to fulfil certain criteria.

The Criteria.

(1) They had to be British. If I had included women from foreign cultures in such a small-scale study, the multitude of different perceptions and interpretations which they would have had would have obscured the analysis.

(2) It had to be their first pregnancy. Women who already had children, or previously had terminations or miscarriages were excluded from the main sample as some of their perceptions of pregnancy would have already been formed. (However, as I explained in the previous chapter, I did have a sub-group of multiparous women for purposes of comparison.)

(3) They had to be married or enjoying a stable cohabitation. I felt that single girls faced additional problems precisely because they were single, which again could have obscured the main issues facing 'ordinary' women.

(4) As I had chosen to focus on the middle ranges, the women and their husbands had to fall outside the managerial ranks on the basis of the socio-economic classification of occupations.

Every classificatory scale has shortcomings, as Goldthorpe and Hope (3) have amply demonstrated. They have produced a very detailed and comprehensive scale, but unfortunately I was unable to use it as it was not published until well after I began my work. Given the scales which were then available, I felt that the socio-economic classification (4) more nearly met my needs than the Registrar General's Social Classes I-V as instead of merely taking occupation as the criterion, socio-economic groups "contain people whose social, cultural and recreational standards and behaviour are similar." Therefore, I excluded women if

they or their husbands fell outside socio-economic groups 1-4.(5).

How Far Did the Women Meet the Criteria?

The Table in Appendix 11 shows the women's ages, their type of housing, their occupation and that of their husbands and parents. It shows that none of the couples fell within the managerial groups. They also fell outside groups 13, 14 and 15 (farmers - employers and managers, farmers - own account and agricultural workers.) Julie's father was the only parent of managerial rank.

All the women were British. Julie was English and Ruth was from Northern Ireland, but all the rest of the girls were Lowlands Scots, the majority coming from the Edinburgh area.

None of them had been pregnant before. Brenda, Pamela and Joan became pregnant whilst they were single, but by the time I contacted them, all the women were married except Lynne. However, she had been cohabiting with the father of her child for some time and their relationship seemed very stable.

Other Relevant Characteristics of the Group

As regards educational qualifications, only Wendy and Joan stayed on at school after 'O' level standard. Wendy had wanted to become a teacher but had abandoned this at the last moment and had no regrets. Joan obtained Higher passes in two subjects and went to Art College for a year. She failed her first year examinations and then became unemployed.

I imposed no age limit on the group. The youngest girl was seventeen, and the eldest thirty.

PART II : THE ANALYSIS

Introduction

"If something's going to happen to you, you might as well know what it's about. I mean, you DO know things like - how you're growing up, you know, ORDINARY things that happen to everybody. And that's just another thing. (pause) In fact, I was thinking that women should be told all about it BEFORE they're going to have children. It might just put them off. I'm sure it would (laughs) you know, the whole process involved. It might just make them think. I think they should be told at school. I didn't know. And I remember, when I first started work, the women were talking about some girl, one of their daughters, I think, had had a baby. And they were just talking about, oh, all sorts of things like, you know, when her labour started, and I just didn't know what they were talking about - I didn't understand ANY of the terms, or the process involved, or anything. It's all a wee bit frightening. But if I'd known all about it, I'm sure it would - HELP, you know."

Joan's ignorance and uncertainty about pregnancy were typical. Uncertainty abounds during all status passages in industrial societies, and some of the reasons for this have been discussed in the literature. Rapoport and Rapoport (1) have said : " In the context of the family development cycle, the major role transitions include the role changes involved in getting married, having a child, children leaving home and one's spouse dying. In the more traditional societies these transition-points tend to be marked by ceremonial elaboration of ritual activity. These rituals seem to function to ease the transition for all concerned by dealing with the psychic and social implications of the changes entailed (van Gennep)(2). Given the relative diversity of cultural norms, and the secularization of, and the rapidity of social changes in, modern society, each of these significant role transitions, however prosaic, involves some degree of uncertainty, and tends to be unsupported by traditionally prescribed resolutions."

In addition, anticipatory socialisation for new familial roles is generally

minimal, and the prescriptions for behaviour expected in the new roles may be highly variable (3). The prevalence of uncertainty during pregnancy has been mentioned by several writers (e.g. Hubert (4), Klein, Potter and Dyk (5) and Rayner (6)).

As uncertainty underlies the process of first pregnancy to such a great extent, it is helpful first to consider the part it plays in the transition. This chapter looks first at the reasons my respondents gave for their uncertainty, which involves a discussion of their attitude towards pregnancy before they conceived. Clearly, the type and degree of uncertainty differs from person to person, and depends on such factors as number of siblings, rank in family, nature of job and type of social network. For instance, Pat, who lived in an old, close-knit part of the city was able to find out a great deal of information "on the grape-vine" once she wanted it, unlike Christine, who had recently moved into the city and lived in a new tower block on the fringes of the town and knew no one. Uncertainty manifests itself in various ways during first pregnancy. Indeed, in a sense most of the issues discussed in the thesis can be considered as manifestations of uncertainty (e.g. body image, sex of the baby, transition to motherhood). Only some of the more central aspects are presented in this chapter ; other instances will appear in context in other parts of the thesis. Here two broad areas of uncertainty are considered : the uncertainty surrounding procedure, and the uncertainty concerning the process of pregnancy itself. To help them pick their way through the transition, the women evolved several coping mechanisms which helped them reduce their uncertainty. Anwar has given a good summary of the history of the uses of the term 'coping mechanism' (7). I follow Silver's use of the term ; he defined it as coming to terms with problems (8).

Many women responded to their uncertainty by casting around for cues. Goffman defines cues as predictive devices (tests, hints, expressive gestures, status symbols) which substitute for the full facts of the situation which can necessarily never be known (9). Cues help the women construct their interpretation of what is going on. Their interpretation may or may not

agree with scientific interpretation of the medical staff. Examples of the importance of cues are given throughout this chapter.

During the work I have tried to unearth the women's assumptions about pregnancy. (I use the term 'assumption' as Goffman defines it, as a strongly held belief which is taken for granted, and is therefore difficult to uncover (10).) However, in the face of such over-riding uncertainty, the women were unable to hold many assumptions, and so it often becomes more pertinent to consider what passes for knowledge (11) in their minds during this period.

In sum, this chapter should present a broad view of uncertainty as it snakes its way through first pregnancy. It also provides a back-cloth against which all other reactions and experiences should be set.

Explanations of Uncertainty

Nash, Jessner and Abse said that most of their primiparae had a "vacuum where their education about pregnancy, childbirth and parenthood should be" (12). Similarly, before becoming pregnant, most of my women had only a limited and superficial impression of what pregnancy entailed. Berger and Luckman have discussed the body of role-specific language which must be learned when one undergoes secondary socialisation (11). Some women, like Joan, were ignorant of these technical terms. For example, Brenda had never heard the term 'ante-natal' and so when the nurse asked her and her sister if she had come along for ante-natal the two girls could only look at each other in bewilderment and embarrassment until the sister blurted out, "She's pregnant!"

Maggie probably summed up the general feeling when she said, "I didn't really know much about it. I thought there was, you know, just being pregnant, well, you always just think of morning sickness and -- having the baby! (giggle) You know, the pains of having the baby. That's all, and your stomach gets fatter. That's all I used to think. I never actually ever thought about it myself, because -- I don't think it's a thing you think about of yourself until you're actually having one" (13).

Maggie's last remark was significant. Before they became pregnant, most of these women were not interested in pregnancy. The reasons for their lack of interest reflected their varying perceptions both of pregnancy and themselves. For example, Jean placed pregnancy firmly in a sexual context : " It never bothered me. As I say, I was a virgin right up to the time I got married, and sex never entered my head. I must've been right backward ! " Wendy explained her former lack of interest in terms of her aversion to " anything medical " : " I had pregnant friends, and I used to visit Jane quite a lot, but I never really took much interest. Because hospitals used to make me feel faint. I used to hate talking about anything medical. Even sometimes when anybody's sick my stomach turns over and I feel ill." Some women seemed to see life as a series of distinct stages, each of which should be lived intensely with no thought for the future stages. For example, Pat said, " I was never interested. See, if I've no got anything to do with it, it doesn't bother me. Governments and that, I couldn't care less. No, if it doesn't involve me, I'm not interested. But when it involves me, I take an interest ... The other two sisters, they would sit and listen, but I wasn't interested. I was wanting to go out and gallivant." Pat believed that there was a right time to start listening to others. Consequently, she began to take notice of her mother-in-law when she was considering having children, because " I thought, 'Well, I'd better listen. Better get some of her tips.' "

Amplifying Pat's argument, Sophie told me, " It's something an awful lot of women don't talk about. They don't feel free to talk about it unless you were likely to ask them. You feel it's a closed subject, pregnancy ... Unless it's something you're actually experiencing, you don't tend to speak to other people about it. I HAD known several pregnant women ... and I was never too interested. O.K. they're having a baby, you know - so what ? They're just not in your social line any more. They're having to stay in and they're having a baby, all excited, and that doesn't concern you any more, so you don't ask." Thus pregnancy was seen only as interesting to those who are or have been pregnant. Sophie believed that social norms dictated that two people had to have their subject in common before it could be discussed together. " It's the same discussing marriage, or your husband

with someone who's not married. Or if you're interested in reading particular books, well, I suppose there's no point in sitting discussing historical novels with someone who's not interested in them. I mean, if you've got a focal point, something in common between two people, they'll talk about it. Apart from that, it's usually courtesy, you know, to ask, 'How are you keeping?' And you think to yourself, oh, here it comes, she's bound to start off! So if anyone asks me I just keep it brief."

This belief inhibited Sophie from passing on knowledge to the uninitiated and helped maintain uncertainty.

Some women never remembered their mothers discussing pregnancy with them. Some received information from their sisters, but this depended both upon the sisters being forthcoming and their enjoying an intimate relationship with each other. Because Joan felt that she had never got on with her elder sister, she regarded her sister's pregnancy as being "just as if the woman next door was pregnant."

Merton has defined anticipatory socialization as the process of learning the norms of a role before being in a social situation where it is appropriate actually to behave in the role. ⁽¹⁴⁾ In this case because these women lacked both interest and available reference ^{groups} /, little anticipatory socialization could be done. This was an important reason why uncertainty was so prevalent during this transition.

Because the women generally lacked friends who were or had recently been pregnant they had few people to whom they could turn for the purposes of comparison or intimate advice. Workmates could often pass on valuable information, but the women only considered other mothers as reliable sources of information. If they did not work beside such women they sadly missed this opportunity, as Kathleen described: "You find out everything at work; really, more or less. If there was women there, you could talk about it and that. But there's nobody there - I'm the first. And I mean, it's not what you'd go and ask MEN about. So - there was nothing, really."

In the absence of any accessible reference group some women tried to use their fellow patients at the Clinic or the Classes in this capacity.

Therefore, when Jean was anxious about her leaking breast, in an attempt to construct a picture of normality she checked with another patient at the Clinic to see if she had had the same problem. But several women told me that they found it difficult to make conversation with the others at the Clinic. Judith described her Clinic visits as follows : " Everyone sort of sits, and they're in their own little individual world, you know. It's quite strange. I thought it would be more, 'Oh, how are you feeling today?' but - I think, as I say, there's a big turn-over and you don't always see the same people when you go. So you don't really get a chance to get to know the women. I suppose - everybody's still sort of living their own life, if you know what I mean. Everybody's got their own little problem, and they're not really interested in anyone else."

The Mothercraft and Relaxation Classes provided another captive audience for those women who chose to attend. During the early Classes several women complained that no one spoke, but as the Classes went on, a freer interchange began to develop. Elspeth in particular was able to use these women as a support group with whom she could discuss her problems.

A friend who had become pregnant recently or who was already a mother usually became a valuable source of information, comparison and reassurance. However, the amount of information friends could impart was limited by the nature of their experience. Gina was keen to learn how to recognize labour, but her friends were unable to help her : " Well, see, the three friends that I have that have HAD kids, like, they've all been started off (i.e. induced), so they canna really tell me anything about the first stages. I was trying to ask them what to expect when it first started - how will I know it's LABOUR, you know." There could also be other problems. For example, Maggie's sister-in-law provided her with all her information, but Maggie added, " But I haven't seen her for about a fortnight. I used to see her quite a lot, but my husband hasn't got the car, so we're not down as much now. And she can't come up here because she's got the wee one, and her husband can't bring her because he's singing in the band in the evening. So, I've not seen her for quite a while - a few weeks. Whereas I'd like to see her more because she's good to talk to. You know, she TELLS you more

about it, and that. I'd like to sort of confide in her."

Even if access were not a problem, difficulties in communication could arise. Some women believed that they could not discuss their pregnancy with certain people. By mapping over her own feelings to her friend and assuming that both would react in the same way in similar circumstances, Elspeth persuaded herself that her friend would be hurt by listening to her talk of pregnancy, which prompted her not to discuss her experiences. She told me : " I feel that she's not pregnant, and I know she'd quite like to be pregnant, but they feel that they're students, and they're going to wait until he finishes. So it wouldn't be very fair, me talking all the time about it when I see her, because I know if it was me, I would feel it - if it was her, you know." The delicacy Elspeth showed here seemed to be fairly typical, and proved an effective barrier to communication. Her mother might be expected to be a girl's greatest confidant, but Elspeth felt unable to discuss her ailments with her mother : " I don't like talking to my Mum a lot, you know, and worry her, 'I had these pains in my stomach', or something. 'Oh, have you told the doctor? You'd better tell the doctor about it', you know and you say, 'It's alright', you know. I think I'd better not say too much."

There was another reason why mothers did not always make good confidants. Gina was one of a few women who told me that she felt unable to discuss her pregnancy with her mother because of her perception of pregnancy as a sexual matter and her embarrassment at discussing sexual affairs with her parents : " I canna really talk about it to my Mum and Dad. It's just (sigh) they're so - I wouldna say they're too narrow-minded, but towards their own FAMILY they are. Sex is a dirty word, sort of style. My Mum gets embarrassed; she'll start to talk about her labour, and then it tapers away to nothing, you know."

Jean did not mention her pregnancy to her sister because she believed that her sister's attitude of ' there's no point in asking questions because you make yourself worse' inhibited confidences.

But perhaps the most important and widespread attitude here was the desire of the informant not to alarm the novice. Sheena told me, " You know my friend that had the baby in September ? Although she never said to me that

it was a long time, because by that time I was expecting, and she never said anything about the birth or anything, in case maybe - because she DID have a bad time, and I guessed she had a bad time. Although she never said anything to me. But she got started off one night, but it was the following day before the baby was born. And I saw her a couple of weeks back (i.e. after Sheena had had her own baby) and she DID have a bad time. She told me then, but she never told me at the time."

This 'frightening syndrome' was a very common one. It was interesting that after they had given birth, most of the women (including those who thought they had had an easy time) said that they would not tell a girl who had not had a baby much about their labour in case it frightened her. The 'frightening syndrome' thus served to increase uncertainty as to what birth was really like (15).

There was also the difficulty of knowing what to believe. It seems that some women took a delight in recounting lurid tales of pregnancy and childbirth, ostensibly as a joke. At best, this left the listeners unsure as to what actually happened; at worst, it terrified them. As Alison told me, "You hear all the different wee stories, and you never ken what IS going to happen when you do go in. Different folk say 'Aye, you'll ken all about it when you go in. You're holding the bed and you're screaming.' And then somebody'll say 'Oh, I never swore in my life 'till I went in to have my first', and this is the way they go on. I says, 'Oh' (weakly). But half of them tease you. The women in the work, they had me up to ninety. They were kidding me on, telling me all the different things (giggles) and I was sitting going 'Really'. I was believing them. I mean, you're ^{not} so ignorant as what your Mum and that likes was, but, I mean, when people tell you something, you dinna ken if they're kidding or no."

Most women evolved mechanisms which enabled them to defuse the horrific stories they heard. The bulk of these will be discussed in the chapter on pain, but one or two of the more important beliefs are outlined here.

Beliefs

The women were able to undercut many of the stories they were told by clinging to certain beliefs. One such was that we live in times of rapid

change. This was useful in that it reassured them that the information that others passed on soon became obsolete anyway (16). It also meant that they were circumspect about whom they would listen to; mothers who bore their last child more than about five years ago were not seen as reliable informants. (This applied particularly to areas such as hospital treatment and procedure - as Helen said, "They're always bringing in new methods at the hospital.") For example, Christine believed it was more sensible to attend Mothercraft Classes than listen to other people's advice about baby care : " Oh, I've spoken about it to my mother, but she says 'What's the point in asking me?', she says, 'It's a long time since I've had any! ' And everybody that I speak to says things have changed that much. You sort of say, 'I was at the Mothercraft Classes and I got this and I got that.' And they'll say, 'Well, you know, it's been ages since my kids were young, and you're better going to classes and finding out what's what.'"

Perhaps the major belief that the women held was that 'everybody's different' . This all-purpose belief was used in relation to various aspects of pregnancy (e.g. pain and body image) and it served different functions at different times. For example, sometimes it was used as a coping mechanism for pain, sometimes as a rationale for certain types of behaviour as a mother. It was also widely used as a coping mechanism for uncertainty: if everyone experiences pregnancy and birth differently, one cannot know exactly what either process will be like. Certainty then becomes impossible, and uncertainty right and inevitable. And, if everybody's different, one cannot learn much from listening to others, as Pamela explained : " I know what's coming - and yet I don't, sort of thing. People can tell you what it's like, but I mean, every birth isn't the same, you know." In this way the belief played an important part in defusing horrific tales, particularly about childbirth (17).

The women also tended to think that no one could possibly explain what pregnancy and childbirth were like. Therefore, it followed that the only way to find out was to experience it oneself. Related to this was the

belief that it was impossible to predict one's reactions in future situations. For instance, Julie said that she did not expect to feel frightened when handling her baby, but added " I won't know 'till I've actually had it." All these beliefs can be seen as helping to rationalise the existence of uncertainty.

One result was that the women themselves were reluctant to give advice to other primiparae. As Jean said, in her third interview, " There isna any advice to give anybody. Because no advice can help them. They've just got to help themselves." Thus uncertainty was perpetuated.

Conclusion

All the women experienced some uncertainty. Those who seemed more confident and informed about the process tended to be those who felt warmly towards children and were keen to become mothers themselves. Some were members of large families and had helped their younger brothers and sisters grow up. It was not surprising that these women felt less uncertain as new mothers than most. Work could also teach some women about pregnancy and motherhood - for instance, Julie learnt a lot in her job as a nursery nurse. Other women had read magazine articles on the subject. But none of the women felt that they knew everything about the process. Even Julie, who had officiated at several births, told me that although she had " gone through it on the outside" it was entirely different " on the inside. When it's on the outside, it's just a person, it's just another one. Whereas, when it's you, you're IT, you know, and it's so different."

Given the unknown quantity of birth and the foetus, some uncertainty during pregnancy would always seem to be inevitable. However, there would seem to be additional causes of uncertainty in our society. Firstly, there are structural reasons causing the privatization of status passages. Then there is the women's prior general disinterest in the transition; and thirdly there are the various difficulties they encounter in gaining knowledge from friends. All of these factors combine to heighten uncertainty until it pervades the whole process of pregnancy and eventually comes to be seen as the norm.

Examples of Uncertainty

Introduction

This section looks at some specific areas of uncertainty and discusses some of the ways the women found to cope with them.

The girls felt uncertain about a wide range of issues. For example, some were apprehensive as to what being in hospital would be like, whilst others found difficulty in understanding their feelings at certain stages.

Elsbeth was someone who felt very unsure about the effect drugs might have on the foetus, and Joan never satisfactorily solved her dilemma as to how much she could safely drink. Most of them expressed uncertainty as to their appearance (18) (especially at the end of their pregnancy and after the birth), and about the labour (17). They also worried about the foetus - what sex would it be, and would it be 'alright' (19). Baby care could all too easily degenerate into a morass of uncertainty: would they know when something was wrong with their baby, and would they manage to unravel the intricacies of when to put him onto solids? (20) It was not surprising that some of them began to wonder if they were reacting 'normally' during their pregnancies. Their anxiety reflected the lack of any clearly-defined pregnancy role and their relative isolation from any effective reference group. Ruth voiced this when she asked me if she were atypical in feeling happy at being pregnant: "When I go down to the doctor he'll say, 'Are you happy?' I'll say, 'Of course I'm happy'. He'll say, 'Well, you're the only one who says you're happy in their pregnancy'. I mean, I often wonder how other people feel. About being pregnant. I've ALWAYS been happy at the idea of actually going to have a baby. But it made me wonder what other people say to you when you go. I mean, do they normally groan about it?"

It is clear that uncertainty ranges very widely in first pregnancy. This chapter focuses on two broad areas of uncertainty: the process of pregnancy and the procedure during it. It ends with a discussion of the role of the medical staff vis-a-vis uncertainty. It is important to realise that throughout pregnancy the difficulties posed by uncertainty are exacerbated by the women's assumption that they must not blunder and 'show themselves

up'. Naturally, in the face of so much uncertainty, this goal is difficult to realise, but it underlies and explains much of their behaviour.

(1) Procedure

(i) The Visit to the G.P. to Confirm the Pregnancy

All the girls went to the G.P. to have their pregnancy confirmed, even though some of them felt sure that they were already pregnant. As Pat said, they wanted "official confirmation". This confirmatory visit can stir up a welter of emotions, but there seem to be three main foci for uncertainty: the timing of the visit, the confirmation of their pregnancy and, for a few women, the announcement of the reason for their visit (21). Most of the women were unsure when they should go to the doctor. The crux of their dilemma was their ignorance as to when the doctor would be able to 'tell' they were pregnant. None of them wanted to have Gina's experience of attending too soon and being told to return later ("I could have died ... he said he couldn't tell and I had to come back in a fortnight.") In addition to feeling frustrated and disappointed, Gina felt that she had made a fool of herself in showing that she did not know the right time to attend. They therefore had to learn what the right time was, and they usually learnt by asking friends' advice. Pat told me how she had timed her visit: "It was Frieda. I just took all my information off her. Because I was never really interested before 'till it actually happened, and then you're running about mad getting all the information. So she had said about sixteen, seventeen days - somebody had told her, you know, the usual, the grapevine. So that was that, I just sort of picked it up from Frieda."

Elsbeth observed her workmates and picked up the cues: "Well, I knew you had to wait a fortnight." When I asked her how she knew, she said, "Just people at work - things like that, you know. Well, there's a girl who'd gone, two months before; I think she'd gone to one of those laboratory things, and they told HER. She was only fourteen days late, and she knew then, you know. So, just seemed to pick it up from work that you could tell

after a fortnight."

All the women assumed that they should be able to tell when they were pregnant. This was an important assumption as it meant that if their test was negative they felt foolish and embarrassed at having been proved wrong. (This explained why Christine said she would have felt embarrassed if she had again seen the same doctor who had diagnosed her previous false alarm). But there are difficulties in diagnosing pregnancy for the first time. Ruth expressed them very clearly when she described how she had felt when her doctor had asked her if she felt pregnant : " I said, 'Well, I've never felt pregnant before, so I don't know.' I mean, I think it was a silly question to say 'Do you feel pregnant?' Because, I mean, if you've had a baby before, you're bound to KNOW how you feel. But when something's just happening to you for the first time -- I said, 'Well, I feel my body has changed a bit ! ', I said, 'But, I don't know whether I feel pregnant or not', I says, 'I'm hoping I am.' He said, 'But that's no answer for me.' And, I said, 'What do you want me to say ?', I said, 'I've never had a baby before, so I don't know how you're supposed to feel.'"

Recognising pregnancy depends on the ability to read cues. Throughout the centuries people have acknowledged various cues as signs of pregnancy (22).

In my sample, all the women recognised the obvious cue of a missed period.

For those whose menstrual pattern was extremely regular this was enough

to make them feel certain that they were pregnant. They would tell me that they 'knew' , but they "just wanted it confirmed by a doctor."

However, for the other, less regular women, more cues were necessary before they felt convinced. Sheena took an easy way out : " Well, at first I wasna very sure because I was never very regular, and I didna want to go just after - you know how they say go when you're six weeks ? Well, I wasna very sure, and I thought, well I'll wait and see if I miss two complete periods and then I would go to the doctor. And by then I thought, well, there would be something."

Pamela was able to recognise other cues : " Well, I knew myself what the result would be. I mean, I just knew. I FELT different (23). You know ? I thought, when you fell pregnant, you didna get any symptoms or anything

'till you were two or three months. But I got them really early. I felt myself getting fatter and fatter. And well, I knew what it was anyway." But cues can be difficult to interpret. Maggie told me, "I missed my period.. But I didn't have any side-effects or that. So I didn't really know. You know, I kept on having the pain in my stomach that I was going to take my period and that but they didn't come. But you know, I didn't have -- I didn't FEEL any different. I had pains - you know how you usually get pains in your stomach when your periods ARE coming ? Well, I thought maybe they're just going to be late, because I had lost my prescription for my pill. And I hadn't TAKEN my pill. So I thought, maybe it's just with me being ON it, and coming off it so sudden. But I did expect to be sick, because my SISTER, when she was pregnant, she was awful sick. And I always thought, well when you were pregnant, I always thought you found out that way. So my husband says to me, he says, 'You'd better go to the doctor', he says, 'And find out if you are.'"

One way of coping with the difficulty of recognising cues was to get confirmation from experienced friends that these cues were the right ones : "I told my friend all the symptoms and all the things I had - actually, she told me first that she was pregnant. She told me all of what she had, so I heard her describing what the symptoms were, and of course, I thought, 'Well, that must be me !' (giggles) So I says, 'Oh, I think I'm pregnant', you know. Find out everything first before I telled her."

Because the women thought that they should be able to diagnose their own pregnancy, their meeting with their 'G.P. could become a difficult and potentially threatening encounter if they felt that they had not piled up enough cues to convince themselves that they were right in thinking they were pregnant. Such was the case with Sophie. She felt very uncertain as to whether or not she was pregnant. Not only had she none of the 'usual symptoms', but she had had so many 'false alarms' in the past "that you get to thinking, well, you know, it's not positive." And then there was the sheer conceptual difficulty of imagining herself as a mother : "And having been MARRIED, of course for eight years, and there's just been the two of us for so long, I could just never ever imagine myself as BEING a mother." She coped with this situation in three ways. Firstly, she reduced

the apparent importance of her visit by ostensibly seeing the doctor about her varicose veins, and presenting the question of her possible pregnancy very much as a side-issue. She then tried hard to convince herself that she was not pregnant, and continually rehearsed the scenario of being told that her result was negative : " I kept THINKING, well, I'm not pregnant, and they're sure to come, you know. What a fool I'm going to be when I 'phone up the doctor and she says, 'Well, you're not pregnant', and I think, well, I didn't think I was anyway, because ... you know!" And thirdly, she took care to choose a doctor whom she expected would not ridicule her if she were mistaken : " They had told me who was on, and the doctors I normally saw, one was on holiday, and one wasn't there, so she gave me a choice of two, one male and one female. So I thought, well, I'll go to the female one, you know. Not that I'm SHY with men, or anything - far from it, but I just like the lady-doctor sort of attitude. O.K. you're both females, so I think they're more in tune with what you're thinking, with the sorts of things you're going along with, rather than male doctors. And if you're going along with a sort of personal problem, I think it's maybe easier, telling a woman doctor rather than a man doctor. Not so embarrassing. And of course, when she said, 'You can take Dr. so-and-so, or Dr. Fowler, you know. She's a lady,' and I thought to myself, well, maybe going to a man doctor, and saying, you know, 'Do you think, you know, I'm sort of pregnant?' Maybe asking for sedatives TOO, you know, sedatives for the varicose veins, they might have said, 'Oh don't be ridiculous, girl ! ', you know, 'Of COURSE you can't be pregnant.' I wasn't too sure about the attitude I might have invoked. So I thought, well, it had better be Dr. Fowler, then. And the fact that she'd got the same Christian name as me, I thought, well, it's a good omen !"

She was conscious that her attending the doctor ten days after she had missed her period might seem rather premature, so she coped by defining her visit as primarily one to do with her varicose veins, and emphasising that normally she would "never have dreamt" of consulting a doctor so quickly.

(ii) The Visit to the Booking Clinic

As the women knew so little about pregnancy, it was not surprising that they were ignorant of what went on at the Booking Clinic. All the hospitals sent out letters explaining their procedure, but many women still felt anxious and uncertain about their visit. As Julie said, despite the letter, " You didn't REALLY know what was going to happen when you went in to see the doctor. You didn't REALLY know exactly what sort of questions they were going to ask."

Their uncertainty should be seen in conjunction with their embarrassment about the internal examinations, which is discussed in Chapter Seven.

This section looks at their more diffuse anxiety about the unknown. Pat explained it as follows : " Well, that's the first time I'VE been, and you're wondering WHAT they're going to do to you. It's the unknown that terrifies me. I'm alright if I know what's going to happen." Pat tried to cope with her uncertainty by asking friends what happened, but some women, like Helen, were unable to do this : " I didn't have a clue, you know. Well, my sister-in-law, she went to a completely different hospital, she lived outside the city. So she couldn't tell me much. I suppose, well, other friends, I'd sort of lost touch with the ones that had got families, or they lived away from town, you know. And all my other friends, they don't have any family, you know, so -- I suppose I could have gone and said to my half-sister, you know, she's a lot older than me, 'What happened when YOU went ?' That was YEARS ago, you know; but no, I just thought, 'Oh, well.'"

Friends' accounts could also increase uncertainty. Elspeth was worried because she felt that she " just didn't know what was coming 'round the corner, because the way everybody at work was talking, there seemed to be so MANY things that were going to happen." She went on to explain their accounts as " maybe just old wives' tales. The thing is, they didn't do half these things when a lot of them were going, according to my mother (and my Mum's the same age as these women at work)."

A lot of women were particularly concerned about the design of the hospital building (24). Sheena told me that she was worried " in case I go in the wrong doors and things like that. This is what bothers me more than actually

getting anything done. I was fair worried I'd end up in a maternity ward or something." Gross and Stone have said," To avoid embarrassment, people will go to great lengths to insure their appearance in appropriate places" (24). Sheena tried to "insure (her) appearance" by checking the details with a friend : " So I asked the girl who was in the work, I said, 'Now, where exactly do I go, and what door do I go through ?'" Helen had nobody to ask. Through unfamiliarity and ambiguous questions she did find herself in the embarrassing position of being in the wrong queue : " Of course, I didn't know where it was, you know, I hadn't been down to the hospital before. So I was sort of lost. I was sitting in the queue for the END of the process. There was a lady sitting next to me , and I said, 'Is this the booking in?' And - which it IS booking in, but it's the wrong booking in. You're being booked in for the hospital after you've gone through the examinations." It took her time to pick up the cues that she was in the wrong place. " And then she thought about it, and I saw a lady over at the door who was directing people, but I had come in the wrong door, you see (nervous laugh). So I saw her looking at me, and I began to wonder, I thought, oh, er, I'm probably not IN the right queue, and I asked her again." This time she made her question more explicit : " I said, 'This is my first time here, you know. It's just er I haven't been before.' 'Oh, no, this is the END of the queue,' she says. 'You go over there,' and a lady directed me' after that. It's a little bit strange, you know, when you first go, you don't know where exactly to go and who to see first."

Undressing for the examination was another upsetting area. Jean found this experience particularly un-nerving as she felt the cues given her by the medical staff were either non-existent or misleadingly vague. There were no signs telling her what to do, and the nurses' information was embarrassingly incomplete : " Instead of saying to you, 'Strip right down - leave your bra on, but strip everything else off' - instead of saying, 'Leave your underwear on' - you'll naturally leave your pants on, and you're not supposed to. Oh, they are vague ! " Jean was reduced to learning the procedure from other patients who had been before.

Most women developed mechanisms to help them cope with their uncertainty.

Alison, for example, concentrated on her self-image and used the 'I am not the only one' technique. She told me that she was glad that all the other women at the Clinic on her day were primigravidae as then, "it wasna so bad, they were all strange." As we have seen, friends could play an important part. Before the appointment they could unravel the mysteries of what went on and offer general reassurance about hospitals, or they could even accompany the women to the Clinic. Christine, however, discounted all help from others. She maintained that she did not want anybody to tell her about it: "I'd rather somebody didn't tell me all the details, because then I can find out for myself. Because you know what it's like if somebody says one thing about something, and you go and find it's not like what they've said it is. Or you've maybe picked them up wrong. So, I'd rather find out for myself." In this way Christine justified her uncertainty. The women's uncertainty undoubtedly contributed towards their anxiety. When this is added to the embarrassment they felt about the examinations it is easy to understand why the appointment at the Booking Clinic was seen as so alarming.

(iii) The Choice of Hospital

It was policy for the G.P.s to ask their patients which of the four maternity hospitals they wanted to go to. (Primiparae were not allowed to have their babies at home.) Therefore, on the face of it it seemed that the women enjoyed free choice. But most of them knew very little about the hospitals. Some of them did not even know their names and whereabouts, let alone their practice. In these circumstances, a reasoned choice based on full information was impossible.

How then did the women make their choice? In the absence of any real certainty, it seemed that they based their decision on beliefs about hospitals which passed as knowledge. For example, there was a widespread belief that a modern hospital was the best choice. There were several factors here. One was the assumption that hospitals were depressing and childbirth and the time in hospital were dreary, unpleasant occasions when one needs cheering-up. As Sophie explained, a modern hospital was regarded as one

way of making them feel a little happier : " I think hospital surroundings are very important to the patient - they must be. I think if the surroundings are nice,modern,sparkling and new,really,to ANYBODY they're much preferable than the old-fashioned idea of the pale green walls and pipes running along the ceiling,and all the paint chipping off the ceiling and the walls. You know,there always seems to be such an air of GLOOM about these old hospitals,and nothing looks NEW at all. There's just tatty,faded cotton bedspreads and curtains and such things. No,I do think the surroundings are important,and I think it's well worth the amount of money that's spent on modernizing hospitals and having everything gleaming new. It's so much nicer. And it does serve a lot more to putting you at your ease. It's just,I think,a modern approach. And,I suppose, combine this with the youthful looks of the doctors and nurses,along with the modern surroundings and the modern approach,and it goes a long way towards putting people at their ease."

Secondly,they believed that modern hospitals somehow gave better treatment. This was partly because they thought that modern hospitals must have modern equipment,which they expected would necessarily increase their safety during labour. In this way their faith in modern technological achievement functioned as a coping mechanism for their anxiety as to their safety during labour. Some of the women also believed that " modern hospitals have modern ideas". By this they meant that they thought the staff would not let them suffer unduly as,to them,the modern attitude towards pain was to kill it (25). In this sense,their choice of a modern hospital was in part a coping mechanism for pain (see Chapter Eight). Some girls told me that they thought they should go to the hospital where they themselves or a near relative had been born. Presumably the assumption here was that this hospital had been 'proved safe',as well as a feeling that it was fitting to carry on the family tradition (see Anna's idea that one should have "loyalty" towards the hospital one was born in .) Many women were concerned to choose a hospital which was fairly near home so that travelling to the Clinic would not be too arduous or expensive,and

so that it would be easy to reach once labour had begun. Helen said, " Well, it's the nearest one. As you know, we don't have a car, and if the baby was due, it's the quickest one to get to in a taxi, you know! That's what I was thinking about REALLY, I think, in the back of my mind. Don't want to be caught out." Knowing that the hospital was close at hand helped them feel less anxious that they might miss-time their contractions and give birth on the way there (26).

Some women wanted a hospital which would give them good, personal treatment, and it was often assumed that there was a relationship between personal treatment and size. Gina was determined not to go to the Victoria (27) because she thought it was too big : " They don't have time to give you that extra individual attention." Sophie's reasoning was a variation on the theme 'familiarity breeds contempt' : " Another thing I heard (I don't know if there's anything in it), but nurses in one of these maternity-only hospitals, like the Nightingale and the Victoria part, they're sort of maternity all the time, so they tend to be, perhaps, a bit used to what they're doing. So one mother's just the same as any other mother. But in a hospital like the City or North Hill, they perhaps take a stage of duty, so many wards, so that maternity's just another one to them, you know, so it's maybe more of a novelty to them. So therefore perhaps the treatment that you're going to get is maybe that wee bit nicer than somebody who's handling babies or seeing expectant mothers, or newly confined mothers, or whatever all the time."

These were some of the basic beliefs that the women held about hospitals. But in order to be able to act upon them, they needed certain basic information about the hospitals, and, as we have seen, this was often lacking. There were three main ways of gaining impressions of the hospitals. Probably the simplest entailed merely looking at the hospitals from the outside. Elspeth tried this method, but it rebounded on her : " I wanted the City, but I said, North Hill! I'd passed it in the car when we were coming through here to decorate the flat before we moved in. I remember

passing it then and it was a big new building, and I wanted to go there because it was a brand new one. Well, I THINK it's a brand new one. It's a brand new building, anyway, you know. And I thought, oh, it'll have all the latest things. But I had to ask the doctor which was the City and which was North Hill, and I must have been excited or something. I got mixed up." Perhaps the fact that it is easy to see the outside of a hospital partly explains the popular emphasis upon modernity. The assumption that a modern building must house modern equipment and modern methodology helped the women persuade themselves that they were making a seemingly rational choice in choosing a hospital which boasted a modern building.

The other ways of gaining information were through listening to friends' accounts of their experiences and through what observations they could make themselves when they visited friends in hospital. Pat's friends had given her an unusually full picture: "Frieda was in the City, and Jan and one or two other people were there, and they says it was really nice. They said the ward was beautiful and the nurses and doctors were really nice. And they says the hospital itself was really nice, the labour suite and all the wards was gorgeous - right modern and that. Ken, it wasn't so bad lying looking at something cheerful when you're in labour, than lying in a drab room, which I suppose is quite true. So they says it was smashing - 'If you can, get into the City.'"

She could also draw on her sister's experience in the Victoria: "She sort of liked it and she didn't like it. She said there was this big auxiliary, she used to come and throw you out of bed. She says, 'Oh, I didn't like her at all, she was awful course!' And she says the meals were terrible. And I'm a right good eater, I like my meals. Oh, see, if they gave me a rotten meal, I'd go mad, I'd be coming home!"

She knew from another friend that the Nightingale was drab and she assumed that North Hill was a bad choice because she knew that her friend's daughter had signed herself out from there. Because she had all this information, Pat was able to act upon some of her beliefs (for example, those concerning modern hospitals) and attempt some sort of reasoned choice. But even she seemed to know little about the differences in hospital practice.

Hospitals have different attitudes towards feeding, for example, and different rules about access to the baby; these can become important considerations once the mother is in hospital, and can have an effect upon how quickly she feels confident in caring for her baby. But because the women were ignorant of these differences they were unable to take them into consideration when they were choosing their hospital.

Several women thought the information they were given by friends was questionable anyway, often because it conflicted with other beliefs they held. For instance, Sophie believed that any account of a confinement inevitably reflected the teller's personality more than the standard of the hospital. Julie felt that all women automatically supported the hospital they had been to : " And then they're all for the one they've been to, and calling all the others, you know ! They're all the same. I take no notice of that though." Jean and Lynne received conflicting advice. Jean said, " Some people say 'Nightingale's the best, Victoria's rotten.' and then other people say 'Victoria's best, Nightingale's rotten,' so it's really one and one." Both girls coped with this situation by deciding not to listen to any accounts, but to make up their own minds ("You've got to find out for yourself.")

Therefore, when information was patently incomplete or its validity deemed in question, the women were confronted with absolute uncertainty. Their decisions thus degenerated into haphazard guesses. Julie summed this up : " The doctor said, 'Well, which one?' I said, 'Well, I only know one, and that's the Victoria.' 'Oh, alright then.' (gasps of laughter) I could've said ANYTHING, you know - I felt as if I could have. I would've liked ^{him} to have said, 'That's a good hospital ', or 'That's a good choice', or 'Well, so-and-so's a good hospital. Wouldn't you like to go there ?' You know, I would have LIKED that. But as I say, I just knew the one hospital, so that was it. So I got no choice really."

The women resorted to two other coping mechanisms besides the rationalisation of the advantage of finding out for oneself. One was to forfeit their choice and merely leave the decision up to the G.P. (28). This is what

Lynne did : " I left that to Dr.Blake. You know,you hear that many stories about hospitals ; some say the Victoria's good,some say it's bad. So the doctor says to me,'Where would like to go ?' and I says,'I'll leave that up to you. I've heard that many stories,good and bad,I'll leave that up to you.' And he says,'Well,I send most of my mothers to North Hill,and I'm quite happy with it and so are they.' So I said,'That's fine then.'" And finally,a lot of them persuaded themselves that 'all hospitals are the same',the inference being that if all hospitals were the same,it was unimportant which one they chose. Maggie felt this : " I wasn't really fussy,because,I mean,the nurses are all the same,they're doing their jobs. They've all got the same experience. So it doesn't really matter which one you go to."

In conclusion,in the face of prevailing uncertainty,the women formulated various beliefs about hospitals which then passed as knowledge. In order to try and act upon these beliefs,they had to relate them to what they knew about the different hospitals,but this was where their difficulties began ; they either did not have enough information,or what information they had was of questionable validity. To fill this gap they often resorted to coping mechanisms.

(2) Uncertainty About the Process of Pregnancy

(i) Deciding What is Normal

Hubert (4) has pointed out that,despite the amount of attention our culture pays to childbirth,and the high standards of ante-natal care,"many women seem to go through pregnancy with little idea of what is happening to them,and with only vague ideas about what it is normal to expect during pregnancy in terms of symptoms,and what can be done to relieve them."

My women experienced a number of difficulties in defining normality. In this context,normality has two main aspects : (a) it implied that a particular ailment was common among pregnant women,and (b) it encompassed

what could be expected in terms of symptoms during the rest of their pregnancy. This section shows the range of difficulties facing them in establishing normality and describes how they used other sources in their attempts to reach a definition and thereby evaluate their position.

Firstly, there was the sheer difficulty of recognizing the symptom. Next the girls had to decide whether the symptom was normal, and then they might have to consider how severe it could become before it could be said to be abnormal (i.e. requiring medical attention.) If they saw no obvious reason for the cause they might have to cast around, asking advice and picking up cues, until they hit upon an explanation which they found plausible. There seemed to be a lot of luck involved in this haphazard approach. The women tended to look to others to help them work out what was normal; they used them as possible models, whose behaviour they could decide whether or not to copy, and as advisors as to what the future might hold. Books and the Relaxation Classes served a similar function. This preoccupation with normality was important in so far as the women believed that any symptom which was normal was not a cause for alarm or professional attention.

The most basic problem was identifying the symptom. Knowing that pregnant women sometimes had dizzy spells, Joan was left wondering if she had had one: "I've had a couple of suspect dizzy spells, you know. I've sat and wondered if it was or not." Sophie said she was suffering from cramp and then added, "Well, I've never HAD cramp before. I'm just assuming that it HAS been cramp."

Then the woman had to decide if the symptom was normal. After fainting in a neighbour's house Pat checked with a friend to see if this was normal: "I asked Jan. I had heard Jan saying that she kept fainting and that so I gave her a phone and I was telling her. She says, 'Oh, I had that, and I went to the doctor and he said it was quite normal.'"

This problem was exacerbated if the woman knew that it was one which usually occurred during pregnancy. It then became a question of degree: how severe can a symptom be before it becomes abnormal? Jean faced this dilemma over her sickness at the beginning of her pregnancy: "It started so that I was getting it maybe every second day. And it was lasting the whole day. You see, it wasn't coming once a week, it just come I was sick



all the time, you see." She was unsure what she should do ("You dinna ken, everybody's different.") So she asked her sister, who said, "Oh, there must be something wrong with you." Her mother agreed, but her husband assured her it was normal: "He doesna bother. 'No,' he says, 'It's just one of they things, everybody has sickness.'" Jean only found a way out of her dilemma by developing another symptom (headaches) which her husband was prepared to treat as abnormal and to refer to the doctor.

Throughout her pregnancy Wendy repeatedly suffered from abdominal pain. Eventually she was taken into hospital for investigation, but when she first felt the pain she was very uncertain whether this was a symptom she should mention to her doctor. She put this down to ignorance as to what pregnancy entailed: "I think that what's wrong, actually - not what's WRONG, but I don't really know what to expect. I was alright at first when I was fine - it's alright when you're in good health, but if you take the least little ache or pain - not the LEAST little ache or pain, because I expected LITTLE aches and pains. But when you get different things, you don't know. Now I didn't know WHAT to do, whether to call in the doctor, or whether to try and let it go away on its own, or what to do." She summed her situation up as follows: "You don't like to bother the doctor for nothing, you know. You don't know whether it's a normal thing or not." She developed the following coping pattern: "The first time I always phone my mother and say, 'Do you think I should phone the doctor?' and tell her what it is. And she always says, 'Yes.'" Knowing that a friend lost her baby after suffering from pain, Wendy persuaded herself that it was right to contact the doctor as she believed that her pain could be the sign of a miscarriage.

When they experienced a new symptom the women usually cast about for explanations as to its cause. They were satisfied once they found an explanation which seemed plausible (not necessarily one which seemed medically 'correct'). The symptom then became less alarming, especially when they could believe that it would be just a temporary thing which would soon pass away of its own accord. In order to find an explanation for her pains, Sue asked her mother's opinion, and was reassured when she suggested the popular explanation that her pains were probably the result of the

foetus "lying on a nerve." Sophie was reluctant to ask her doctor's advice about the pain in her legs "because when they're so busy I wouldn't like to waste their time unless it was something that was really worrying me." So, she persuaded herself that the pain was merely a small problem which only needed the application of a little "common sense." And she took as a cue a chance comment her doctor made, and used it as the basis for working out an interpretation of her pain herself: "And of course, when I was at the hospital last Monday the doctor said, 'Well, the baby's starting to drop down now.' So the way I figured it, well, it's obviously causing some change to your posture. So the baby is moving position - the position of the weight has been changed, so this must have some bearing on such things as your legs. No doubt once the baby has settled down it's something that'll pass over." And finally, she justified her using indirect rather than direct information by saying, "There's no point in saying to the doctor, because he'll no doubt come OUT with something like that."

Other people helped the women work out their definitions of normality in a variety of ways. They provided a range of experiences against which the girls could set themselves and define their position more clearly. For example, Jean tried to work out if it was normal for breasts to leak copiously towards the end of pregnancy by approaching her sister, mother, G.P. and a girl she sat next to at the Clinic in an attempt to find out if they had or knew of anyone who had had a similar problem. As she concluded, "It's things you never hear other folk talking about, ken, that you say to yourself, 'That's funny.' It can get you worried, ken." Other women could also prepare the girls for what would happen. Judith's sister, for instance, had warned her that although she might feel well in hospital she would probably feel weak once she returned home. In addition, most of the girls used the booklets issued by the hospitals in order to learn what symptoms they could expect during the rest of their pregnancy. These booklets performed the dual function of preparing the women for what was to come, and reassuring them that their symptoms were normal. As Alison said, "If you've got anything wrong, you just need to look it up and see. If it's in the book, you're alright. It's normal."

But the booklets could be misused ; they could lull the women into ignoring a possibly dangerous symptom . This happened with Lynne. She told me that she had always suffered from dizzy spells, and that they had increased in number and severity during pregnancy. She described a particularly embarrassing attack whilst she was working in a strange store, but she reassured herself by reminding herself that the booklet mentioned that pregnant women had dizzy spells, and that they were nothing serious :

" It never really BOTHERED me, you know, because I've taken these dizzy turns. Because I read it in the book, you know, and if I read it in the book, it's O.K. ! It makes you feel a little bit easier when you know it's something that you all go through - it's not as if you shouldn't take these dizzy turns. So if you do take them, you know it's nothing too serious."

The fact that, as she said, " it didn't say it would be THAT bad ", was suppressed (29).

But there were still occasions when the women found themselves completely unprepared for what happened, as Sophie showed : " Another thing I was quite unprepared for was, you know, if you're NOT breast-feeding, the milk comes in, usually on the third day. And that's another kind of quite painful and unpleasant experience. And, you know, I was COMPLETELY unprepared for that. Quite naive, I suppose. I mean, I just didn't reckon on milk coming in if you weren't breast-feeding. Well ! ... There was nothing in any of the books that I'd read about it. And the girls I'd spoken to, my friends or my sister, that have had babies, they've never said much about that. I remember my sister had said, 'Well, you have to take a really good, firm bra when you go in ', and I thought 'What for.?', you know. 'Well', she says, 'You'll NEED it, you know.' But she didn't say anything about pain or discomfort or anything - although I believe she did say that certain girls in her ward had been in tears with the pain. I thought, well, it can't be that bad

surely ? But it was quite unpleasant, especially by the time you get to the third day after you've had your baby. The initial excitement and whatever is just wearing off, and, you know, it's hard to come back to reality. And between your bottom end with the stitches, and your top end with the milk, it's a wee bit unpleasant ! You just think, this is too much, after all I've gone through. Nobody TOLD me about this. Not even at the relaxation classes, they didn't mention breasts at all. Nothing. "

(ii) Recognising Movement

" But at the moment, I haven't felt ANYTHING. So I'm just waiting, you know. Sometimes you feel a sort of flutter in your stomach, and you think 'What's that ?' But it doesn't come again. It doesn't come again. Maybe sometimes if I feel a flutter, I wonder 'I wonder what THAT is ?', you know. I'm always wondering what it's GOING to be like. But I -- don't really know what it would be like, you know, when it came. -- I probably would recognise it when it came, you know, because it couldn't be anything else other than the baby. -- Because sometimes, you know, if you've seen pregnant women, their stomach sort of jumps up. I saw it in my friend. Once. But you sort of think, well, you must FEEL it - it must be different. A different feeling entirely in your stomach. You must know what it's like."

Like Maggie most women were unsure as to whether they would recognise life. As it was a new experience, they were uncertain what sort of sensation they were looking for, and so, recognising life, like recognising labour later on, became an exercise in cue-taking. But the cues were not always positive enough to enable them to recognise movement right away.

Helen was given so many different descriptions of what movement was like that she merely became more confused, whilst Pat and Anna were given cues that they later felt were misleading. Pat was told that movement felt like " a wee butterfly " in the stomach, but she later decided that it was more

like " something hitting against your stomach and jumping." Some women were therefore expecting the wrong sort of sensation, and some, like Maggie, were expecting their foetus immediately to start kicking like a nine-month foetus. Ruth had difficulty in eliciting any specific cue : " I kept saying to my sister 'What does it feel like ? How do you know ?' And she kept saying 'Och, you'll know when it hits you !' You know, but I mean, you don't, REALLY."

The recognition of movement could become a very real and worrying dilemma. Bereft of cues (because she did not have the courage to ask the doctors for any) Brenda floundered in uncertainty. Her anxiety over not feeling life was stimulated by the doctors' repeatedly asking her if she had felt movement, which suggested to her that she should have done : " But when they keep asking me if I've felt any life or anything, with the bairn, I says 'No' - I don't think so anyway. I couldna tell you whether there is or no. I don't know what I'm expecting. I don't know what it's like. What IS it like ? (giggling, but serious) Oh, I dunno what it's like. It might be moving away and I wouldn't know the difference. I'd just think I was getting pains or something." She began to wonder if her failure to recognise movement might mean that there was "something wrong" with the baby : " I think about that quite a lot - I hope it's alright. And, you know, with them keeping asking if I'd felt life yet, I'm going on about there's something wrong. And maybe I'm supposed to, maybe there's something wrong with it." Her inability to question the doctors only increased her uncertainty and anxiety : " I've never mentioned it. They just keep on asking ME. Well, I thought I was supposed to, you know. I just thought there was something wrong, maybe there was something wrong with me -- or the bairn. I don't know. Maybe it's no TIME yet for it. Oh, I dunno. But it does, it gets me worrying and that - ABOUT it no moving, and everybody asking

me if it is yet, and that. I just think maybe it's lying there dead or something."

Brenda's fears were intensified because she felt unable to share them with anyone, as she felt they were too nasty and anxiety-provoking to voice.

Pat felt unable to mention her worries at not feeling life " because they'd be saying 'Och, you're daft - wait your time.'" Like Brenda, Pat picked up the cue that she should feel life at three or four months, and she was very worried when she failed to do so. Her anxieties were stimulated by the experience of her friend Frieda : " But that really worried me. Ken, Frieda, with her losing her bairn. And she hadn't had any movement ... " They were heightened by her interpretation of her G.P.'s behaviour, which she took to mean that all was not well : " And that last time I got sounded he put them things - what are they called ? Stethoscope, that's it. He just went like that, (i.e. hurriedly) and I thought, 'Oh, he didn't listen very long!' " Pat connected this with the fact that Frieda's doctor could not find a heart-beat : " And THAT was all running through my mind, with that doctor just going like THAT, and I thought, 'He's never heard anything, he's been too quick. And I haven't had any movement' - and this is all running through my mind." She felt afraid to ask the doctor what he had heard partly because he was not her usual doctor, but more importantly, because she was frightened of hearing that she too had lost her baby : " I was afraid to ask him in case what happens to me's the same thing that happened to Frieda. It all goes through your mind."

How, in the face of so many possible interpretations, did the women come to recognise movement ? Firstly, they looked at the frequency of the sensation, working on the rough principle that one sensation did not necessarily mean movement. Secondly, if the movement was entirely different from anything else they had previously experienced, they decided that it must be

life. Anna said : " I just KNEW it was, you know. It just felt like movement. It couldn't possibly be your stomach moving - or ANYTHING like that. It was just a different feeling, you know ... I mean, you couldn't mistake it."

Sometimes it needed the doctor to spell out the cues. Kathleen told me, " I didn't really KNOW if it was that at first. And I WONDERED what it was. It was like - like WIND or something. I thought it WAS, you know ! And I felt this for some time. And the doctor says to me last time I was up, he says 'Have you felt any movement yet ?' And I says, 'No.' And he says, 'You HAVEN'T ?' And I says 'No.' And he says 'Have you not felt little twinges at the side or anything ?' I says, 'Oh, yes.' He says 'Well, that's it ' (laughter)!"

In conclusion, nearly all the women were worried that they might not recognise life. Their ability to do so depended on knowing what cues to look out for, and being able to identify them when they occurred, but, for various reasons, others were often unable to offer them adequate help here.

(iii) Recognising the Contractions

Similar problems were encountered in recognising labour, except that this seemed an even more daunting task. Anna made the connection between the two quite explicitly ; discussing how she identified life, she went on : " What I worry about now is how I'm going to know if it's a contraction or not. If I start myself. That's the same sort of feeling as before. I'd say 'How am I going to know it's the baby moving ?'"

Brenda's underlying assumption was that she ought to be able to recognise her contractions - just as Sophie had assumed that she ought to be able to diagnose pregnancy. But as Brenda had " never had the experience before", and had never discussed it with anyone, identification seemed problematical. She worried particularly about how she would distinguish her contractions

from the baby's kicking. In a frantic search for cues, at the end of her pregnancy she went round asking everyone what "her pains" would be like, but she refused to approach the doctors because they might think she was "daft" in not knowing.

Anxiety over recognition was intensified by the ever-present fear of making a blunder (as Sheila put it, "I'm terrified of going too soon - or, you know, too late.") They believed that to perform their part properly they should be able to read their cues well enough to enable them to arrive at hospital at the right time. If they arrived too early or too late, their front would be shattered, they would be revealed to the hospital staff as not in control of the situation, and as a consequence they would be reduced to ill-ease and embarrassment (9).

When Christine went into hospital she was so worried that she might have mis-interpreted her pains that her anxiety about this overcame even her fears about the pain : " The only thing that bothered me when I DID go into hospital was that I might not have been in labour. I kept thinking, well, if I'm not, and I've come all the way here, getting everybody upset and that ! That's what I kept thinking of. It didn't actually bother me - the fact that I was going in didn't worry me. The fact that I was going to put everybody to that bother and it was going to be a false alarm ! Because before they examine you, they PREPARE you and everything. So this is what was worrying me. The fact that they'd got me all ready, and I might go OUT of labour or something like that, you know. This is what I was thinking. I kept thinking, and oh, I kept saying it to the nurse, you know. She says, 'We won't let you out until you have your baby now : '"

Recognising labour became another exercise in picking up cues. Different women hung on to different cues. The most obvious cue they all had was the expected date of delivery. This was rather rough, but it was sometimes

useful in helping women decide if any pains they had before it were signs of real labour or not. The classes and the booklets on pregnancy told them to look for a 'show' and the breaking of their waters as sure signs of labour (30). They were taught that initially contractions would occur at long intervals, but that gradually they would increase in frequency until they were coming every few minutes. It was therefore supposed to be possible to time the contractions and judge by their frequency when was the right time to go into hospital. The impression that the women were often left with was therefore that the onset of labour was amply heralded by a smooth and regular series of events.

Another well-known cue concerned the place of the pain. Women were assured by friends that the pains would start in their back, and it was time to go into hospital when they 'worked round' to the 'front'.

Several women tried to work out what the pain would be like, and some expected that they would know it because they thought it would resemble menstrual pain. Sophie saw this as an important cue : " I reckon I'll recognise one. Mainly because they do say - and I think too what my mother always used to tell me - it was just very like a period pain, but a hundred times worse'. And having suffered quite a bit in my time from period pains - I believe it is, the pain is very similar. I think period pains, you know, you can feel it coming on, and it does seem to reach a peak and then go away again. There's a continual ache along with it. So I reckon if it's like that, but a hundred times worse, well, I'll know one ! "

Sometimes women were told rather vaguely that they would recognise labour because it was unlike anything they had ever felt before. Pamela convinced herself that " you know when it's the real thing." She cited the experience of a friend who went into town shopping after her labour had started, all the time trying to persuade herself that it had not begun, but " really

knowing" that it had.

There could, of course, be too many cues. Pat found herself confused by conflicting cues : " I often say to folk, 'How do you ken when you're in labour ?' They says, 'Oh, you ken, you ken.' And a lot of folk'll say, 'Oh, you have a show.' And other people'll say, 'Your waters break.' And, yet, I read in that book that none of the two could happen, and you could still be in labour. So - just have to wait and see. I dinna ken." As a way out of her uncertainty, she clutched on to the belief that 'you just know' : " Maybe it's a sort of built-in thing. Air-warning signal, that sort of TELLS you when you're ready to go, eh?"

But when labour began, a large number of women did fail to recognise it. This was often because, not realising the variety of cues possible, they waited for their particular cue to come up and failed to recognise others which were already presenting themselves. In addition, they sometimes tried to convince themselves that they were not feeling contractions because they were frightened of childbirth.

This is what happened to Gina. She felt her first pain on going to bed. In the morning she feverishly began ironing, presumably in an attempt to repress the dreaded pain. One of her friends, herself already a mother, diagnosed labour : " A couple of my friends came up in the afternoon. And one of them is sitting laughing at me. She says, 'It's labour !' Laughing ! I says, 'Oh, thanks very much !', you know. Making me really happy ! (dryly)." Gina convinced herself that it was wind : " By half-past-ten I was convinced it was wind, though I'd never had wind like THAT before (never WANT to have, either !)" As she explained, her particular cues had not come up : " Well, it kept going away. When they first started, the pains were every ten minutes. And then I got up, and after a wee while they were every TWENTY minutes. Then back to every TEN minutes. Then about every half-an-

hour. Then I wouldna have a pain for maybe an hour and a half. And I thought, it must be wind, because labour's no like this." The smooth progression of pains coming with ever-increasing frequency that she had been led to expect was not happening. Her second cue never occurred : " And, of course, it was all in my back. Well, EVERYBODY had told me, 'It'll come round to the front'; and it never, the whole time. Even when I was getting contractions, the pains were in my back. NEVER, the whole time, came round to the front." She finally identified labour at the third, unmistakable cue - her waters broke : " I can remember running through from the living-room and the water broke when I got here. And my husband, of course, he's shouting through to me, 'That's no wind ! I've never seen anybody with wind like that before ! ' I says, 'I know. It's labour ! ' (whimpering and deflated)." She concluded, " It was just as well my waters broke, or I would have hung on here 'till the last minute, thinking that the pains were going to come round to the front. That's why, when it's your first baby, you shouldna really listen to people, you know. Because I may have held on here until it was too late, expecting the pains to come round to the front."

There has recently been a great deal of controversy over induction (31). Medical opinion has been divided as to how far induction is beneficial or harmful to the mother and her foetus (32), and there has been disquiet that some hospitals seem to have been performing inductions as a matter of course rather than only when really medically necessary (33). There seem to be powerful arguments against indiscriminate induction, but given the great uncertainty my women felt about identifying labour and their fears of making a wrong assessment, it was not surprising that many of them were relieved ^{to} be induced. At least then they were relieved of the burden of diagnosis.

(3) The Medical Staff and Uncertainty

The women considered some doctors as very helpful and informative, but saw others as divulging little. Of course, lack of communication involves two parties, and sometimes reflected the women's reluctance to pose questions. But, as Hubert (4) has pointed out, although medical staff can often with all honesty say that a patient has only to ask for information, it is seldom realized that a comparatively uneducated woman does not always feel that she can ask questions.

There seemed to be various reasons for their silence. Sophie described how the setting inhibited her. She had felt able to discuss matters with her G.P., "but that was a different situation because you're sitting there opposite her, whereas in the hospital you're lying down all the time. So you always get this feeling that you're in, examined and out again. In a doctor's consulting room it's a much quieter atmosphere."

Jean saw the doctors as disconcertingly busy. She said she only saw them for a brief time and so there was little opportunity to talk: "He just says to you, 'Is there any trouble?' and 'How are you feeling?' If you say, 'Fine,' he says, 'Right, that's it.' So you canna, really, even if you had something wrong I wouldna like to say it, or, ken, if it was a wee thing that was worrying you, you canna sort of say to them, 'Oh, there's something worrying me,' and TALK to them, because you feel oh, I'm taking up time. It'd have to be something really bad that's wrong with you."

Maggie put her inability to speak down to her shyness with strangers. She said, "I'm struck dumb. I never know what to say to them, you know. I just sort of get nervous. I think it's just because it's so many people I don't know. I find it hard to talk to people when I meet them for the first time when I don't really know them. And I've always been sort of like that ... I feel as if everybody's looking at me and that. I don't know why. Maybe it's just an inferiority complex ! "

Pat felt able to question only "nice" doctors. "Nice" doctors were the ones who chatted and joked with her and put her at her ease whilst not giving her the impression that they were trying to get rid of her.

Lynne and Julie told themselves that the doctors knew what they were doing, so it was best just to let them proceed (34). This belief provided a very effective rationale for their not questioning the doctors. Others persuaded themselves that the unexplained symptoms they had had were not worth mentioning because they happened in the past and had now completely disappeared. All these images and beliefs functioned as obstacles to any free discussion with the hospital doctors.

Sometimes it was the procedure which impeded communication. For example, Elspeth had developed a liking for chocolate. When she attended the Clinic she expected the staff would reprimand her for putting on too much weight, but this did not happen : " They never said anything about my weight, actually. I was quite surprised. And quite chuffed. I was WAITING for it. And I couldn't even see what weight I was,because it's funny scales - you stand on a great big scale,and the weight's actually round the other side,on a big dial. You can't see what weight you are. And I'm standing there,ummmmm (trying to peer 'round). She writes it down,on your card, and the doctor gets your card (laughs) and you don't know ! I suppose,I mean,if I'd have asked he'd have told me,but I thought I'd better not ask ! "

The medical staff could increase the women's uncertainty in several ways. They could simply fail to give what the women perceived as direct answers to direct questions. Joan said," I keep asking things like,'Has it dropped yet ?' You know,it's supposed to drop after a certain time. And I never get a very clear answer. You know,he just sort of feels the position,and he never really tells ME anything." Instead of answers,she got what she thought were a lot of compliments : " Well,they're very

friendly. You know, they're very encouraging. The other time I went up, he was feeling the position, and he said, 'That's a nice size for it.' But I think they say that to everybody. Because I was telling another girl, and she said, 'Oh, yes !' (knowingly) They never really answer your questions. You know, they just seem to have all these nice -- compliments and nothing else " (35). In an attempt to interpret the situation so that the doctors' behaviour became understandable and 'correct', she wondered, " Maybe I've just got too many questions."

Roth has discussed the problem of how the patient can know which are the important things to tell his doctor (36). As Roth points out, the doctor does not want the patient to tell him absolutely everything - but he does want him to tell him the significant things. The difficult part is to get the patient to learn which things are significant. A doctor who discourages the patients from telling him many unimportant symptoms may finally discourage them from telling him anything at all. My women also found this a dilemma. If the doctor asked them if they had any problems, as they were uncertain what constituted normality they often did not know which symptoms could be classified as problems. Julie described one such embarrassing experience : " I told him I'd got this pain under my hip, you know. This stabbing - oh ! I said, you know, 'Is it the baby ?' And it kept on knocking me like this, you see. As if it is - really rubbing against me. 'Oh yes', he says. 'It's his hands', he says, 'But there's nothing we can do about it (nonchalantly)'. It's the position it's lying in, and it's very low down, and it's just banging me. So I said, 'Well, is it ? It really feels as if it's going underneath.' And he goes like this - and I thought, oh, he's going to get it out ! REAL DIGS in. (They're not at all gentle, really.) And he says, 'Oh, yes, it's its hand. It's alright, isn't it. (airily - we laugh). Nothing we can do about that.' As if to say 'Why did you bother mentioning it ?' But he TOLD me to mention everything, so I did."

As Sophie had had so little experience with babies, she was unsure how much milk Jane should be taking. Her confusion was heightened by the conflicting advice she received from the nurses at the City : " I found it quite worrying, in fact, that I wasn't sure how MUCH she was supposed to be taking. And some occasions she wouldn't take very much, and they would come along and say 'How much has she taken ?' and I would say, 'Well, er, 35 or 40' or whatever. 'Oh well, that's not very much. She should be taking more.' And I would say, 'Well, how much should she be taking ?' 'Oh well, maybe about 60, 75,' this type of thing. And then next feeding time ANOTHER nurse would come along, 'How much has she taken ?' 'Oh, so much.' 'Oh, that's not so bad.' And the next time you got a completely different story, so I started ASKING them, well, how much SHOULD a baby of this particular age and weight be taking ? And I'd get a different story from each one." She interpreted this situation as follows : " I think so many of them are young girls, they're TRAINEE midwives, and I suppose they're the wrong people to ask, but you reckon they're supposed to know a BIT about what they're doing ... I think they just answer anything just to quieten you off." She found a way out of her dilemma by approaching someone whom she expected should know : " So eventually, I collared one of the staff nurses, and asked HER. And she sort of reassured me. She says, 'Oh, baby'11 soon let you know how much she should be taking,' and not to listen to anyone else." Her solution was for the hospital to give all its trainee midwives " a string of set answers they can give to mothers when they ask them, so they're not all coming out with this conflicting advice ... Because surely the worst thing possible to a mother is to have her worried about feeding."

Doctors often assume that patients speak their language (37), an assumption which tends to prevent less sophisticated patients from obtaining relevant

information. Lynne's doctor seemed to make this assumption when he told her that she was rhesus negative: "The last visit to the hospital, the doctor said he'd have to keep a close eye on me. And I says, 'Why's that?' And he says, well, it's just that I'm a rare blood group, or something. Which shouldn't cause complications in THIS pregnancy, but any future pregnancy. They'd have to keep an eye during this one for future reference like, you know. But I don't know - you know, doctors think you know everything THEY know, and they start rambling off all these big words, you know, and you don't understand it, and you don't know what they mean or nothing." Lynne coped with this situation by persuading herself that all was well because of the doctor's positive tone, and by feigning understanding: "I just left it up to him. I just went, 'Oh yes, aha, O.K.' No, he sounded quite reassuring, you know, that everything would be O.K., and that there shouldn't be any complications."

Several of the women were alarmed at the thought that they might produce twins. As well as doubling the financial burden, the prospect of two babies heightened their anxieties that they would be unable to cope as mothers. There was also the prevalent belief that it was more painful to give birth to twins. Therefore Pat's anxiety during the following encounter can be easily understood: "The doctor was saying, 'Well, what is it to be, a son and heir or a wee girl for you?' I says, 'I'm no really fussy,' I says, 'But I think my man would like a wee laddie.' He says, 'Let's say you'll have twins.' I says, 'Oh, dinna you start!' He says, 'Have you got any twins in the family?' I says, 'My mother-in-law's a twin.' 'Every possibility.' And I'm saying to myself, is he chaffing or is he no chaffing. Then he's saying, 'You're carrying a big baby.' I'm beginning to wonder! I says, 'I get an awful lot of movement'.... He says, 'I only hear one heart-beat, but you never know.' And they kept sort of pulling my leg. And I come out of there, and I'm wondering, have

I got twins or have I no got twins ? And the nurse at the bottom of the bed, she was getting fair serious. She says, 'Oh, now, my dear, if you had two you wouldn't part with them.' I says, 'No, but I wouldna ken what to do with them !' And after seeing the doctor I thought, I've only got one pram ! I was getting quite serious. I thought he was saying to me 'You're going to have twins ' because he was getting -- and then he sort of half smiled to himself, and I thought 'You're a bugger. You're just pulling my leg. ' And after that I sort of chaffed him on a bit."

But more serious and long-lasting were the effects of failure to divulge or explain information. Glaser and Strauss (38) have discussed this problem with reference to patients in a terminal ward : " The patient's objective is to get true indicators of his suspected status i.e. he wants validating cues that tell him 'for sure' . He may attempt to obtain the crucial information first hand, by sneaking a look at his medical charts or by trying to overhear staff conversations. He may also directly query his physician or the nurses." But he still has to interpret the cues. Unless a remark or action is so clear that it tells the true story immediately, the patient must construct his own version of its meaning. Ordinarily a suspicious patient does not have enough medical knowledge to read the many signs that may be available. He must 'put two and two together'. Pat's experience was particularly worrying. She did not understand why she was being taken into hospital earlier than she had expected :

" I went to the Clinic on the Tuesday. I was dead worried, because they kept listening for a heart-beat all the time, and the young nurse was there, and I says, 'Can they no find the heart-beat ?' And she says 'No.' Well, the doctor had went daft because they're no supposed to say anything. And when he came in, (it was Watson, the gynaecologist) HE kept taking the blood pressure. And he says, 'When are you due ?' I says, 'Well, tomorrow.' It was the Wednesday. He says, 'Well, we'll see about getting a bed for you.'

So he came back. He says, 'Come in on THURSDAY.' And I thought he meant the FOLLOWING Thursday because they usually leave you ten days. He says, 'No, THIS Thursday.' Ken, I came out the City, I was coming up the road BUBBLING to myself, because I kept asking them questions and they're not too keen on telling you answers. They cut you off as much as possible. And I thought, oh, there's something wrong, because that nurse says she couldn't find a heart-beat. And oh, I was up to ninety. I says, God, I carried it all the time, I wouldn't like to lose it now."

Pat had failed to recognise any clear answers; instead she picked up the alarming cues that she was being admitted abnormally early, and she assumed that this was because there was something wrong with her baby. But she was unable to work out precisely what might be wrong, because she did not find the cues sufficiently specific. Therefore, on her return home, she turned to her neighbour, an older woman whom she considered particularly well-fitted to help : " And I went through to Vera's - she's had a bairn and lost a bairn, and, Ken, I thought maybe she'll be able to tell me what's what." Vera gave her her reading of the situation; she suggested that Pat's blood pressure was at fault. Pat found this interpretation logical in terms of what had happened : " I says, 'Well, right enough, they took the blood pressure about ten times. They were at it all the time.'" Pat therefore accepted this meaning, and it was not until much later that she discovered the doctors' reasoning, when she found a nurse who was prepared to tell her why they admitted her when they did. She told Pat that her blood was rhesus negative : " She says, 'Did they not tell you, Mrs. Kennedy?' I says, 'I thought it was high blood pressure.' And she looked at the charts. Well, I DID have high blood pressure. And I thought that's what it was. But it was the rhesus negative."

It was therefore easy to understand why, during routine visits to the Clinic, the women enjoyed being guinea pigs. This way they got a much clearer

picture of what was happening. Kathleen told me : " Last week I was used as a sort of guinea pig. I was a wee bit longer than normal. It must have been a couple of nurses doing their midwifery course, and I don't know if it was a sister or something. But she knew a lot about babies and everything, and all the names, and the way the baby was lying. And she explained - I was about half-an-hour on the trolley and normally you're only about five minutes. Normally they don't say - they just say the baby's fine, and things like that, you know. But she explained everything, and she went right through the record card. (That was a bit of a drag, but she seemed to find it quite interesting.) And she had all the nurses having a go, so I didn't mind, really, because she told you which way the baby was lying. So last week I was thrilled to bits, you know. And when my husband came in, I told him all about it."

The medical staff are in a unique position to alleviate the primiparae's uncertainty and anxiety. Not only are they specialists in obstetrics, but they are also in frequent contact with the women throughout pregnancy.

Klein, Potter and Dyk (5) pointed out how the confidence engendered by the belief that they were seen as individuals and not 'cases' in the 'club-like' atmosphere of the Clinic was an important factor in supporting their women through the 'unknown situation' of first pregnancy. But because of difficulties in communication, my women failed to see the medical staff as playing as big a part as they might in reducing uncertainty. Caplan (39) and Bibring (40) have both suggested that obstetricians tend to offer blanket reassurances rather than listening and helping women with their unscientific, irrational and emotional problems. Pregnant women seem to talk easily about their fears (41), and this may have frightened away the medical staff with the result that, as Bibring says, they often fail to offer complete psychological understanding and support. Caplan suggests that the smooth-running large programme that characterises a lot of

maternity services today is made possible precisely because the doctor suppresses or evades his patients' reactions (39). However, he also believes that the improved mortality figures are due to this mass-produced approach, which creates a difficult impasse. His solution is to add another worker, skilled in offering psychological understanding and support to the team. But my respondents felt that it was not just the thorny, emotional problems that were ignored; factual questions, for instance about whether or not one was carrying twins, or the baby was breech, were also seen as being left unanswered. They were therefore driven to picking up cues as to what was going on, and to backing up their impressions with more precise and detailed interpretations from experienced lay people.

Conclusion

This chapter looked at some of the reasons why the women felt uncertain about the transition to motherhood. Some had their foundation in the structure of modern society, where *status* passages are seen as private experiences, which lack clear guidelines as to how they should be accomplished, but many do seem at least partly soluble given changes in medical practice.

Uncertainty pervades first pregnancy, and can often lead to bewilderment and anxiety. Throughout the following chapters it should be remembered that uncertainty provides the backcloth against which other aspects of pregnancy are played out.

CHAPTER FIVE: IDENTITY

Introduction

This chapter looks at the way the women perceived themselves. Sherif (1) has suggested that adolescents in Western industrial societies are "betwixt and between reference groups," very much "marginal men." He argued that their lack of "stable anchors for self" aroused uncertainty and conflict. To a lesser degree, pregnant women in our society could be seen as marginal women; as they pass from one reference group to another, their transition is similarly ill-defined.

The chapter begins with a general discussion of the different self images the women felt were open to them, before going on to examine the processes by which they came to see themselves as pregnant. The second part of the chapter considers one aspect of self image which seemed to be of central importance in the girls' experience of pregnancy, their sexuality. The women generally assumed that as their pregnancy progressed, they gradually lost their sexual identity. This section looks at what the women meant by sexuality and then examines how they came to hold this assumption and the ways by which they were divested of their sexuality. Once the women began to see themselves as non-sexual beings, their behaviour, particularly towards men, changed. The next section considers the effects this new self image had on their life style and their interaction with men. The chapter ends with a brief glance at the imagery the women used about themselves.

As body image plays such an important part in the discussion of identity, this chapter should be seen in conjunction with Chapter Six.

Self image

As McKinlay has said, "expectations and prescriptions surrounding preg-

nancy in Western societies are relatively ill-defined, and in some situations non-existent" (2). My women's experiences were similarly vague. They told me that now they were pregnant they expected to "feel different," but they were unsure in what way. For example, when I asked Julie what she meant by "different," she replied, "I don't know- something special, I think (laughs). No, I thought it would be - I don't know - if you've got measles you feel different, don't you, so I suppose when you're pregnant you're going to feel different, but so far I haven't really." It seemed that "feeling different" was synonymous with "feeling pregnant." (It was significant that Julie immediately went on to say that it was when the foetus kicked that she "remembered" that she was pregnant.) By "feeling pregnant" they meant being reminded that they were carrying a baby, and they could be reminded in three main ways: by putting on weight, by feeling life or by suffering from some of the minor ailments that often accompany pregnancy (e.g. heartburn, constipation.) Seeing themselves as pregnant seemed to have two main elements. Firstly it involved a change in the way the women and others perceived their bodies. (This point is taken up later in the chapter in the discussion of sexuality.) And secondly it was related to the sick role (see Julie's equating pregnancy with measles in the quotation above.) The girls linked pregnancy with the sick role partly because of the ailments they suffered and which they regarded as being part of pregnancy; and partly because they felt obliged to modify their behaviour in order not to harm the foetus (for example, they tried not to carry heavy weights.) This relationship between pregnancy and the sick role was reflected in their language. For instance, they referred to pregnancy as a time when they felt "not well/not right/not a hundred per cent," and they talked of "getting better" once it was over. This was summed up when Pamela told

me that before she gained weight people expressed their disbelief that she was pregnant by saying, "You'd think there was nothing wrong with you." How far she adopted the sick role was a matter for each individual woman to decide. Most women merely tried to "take things easy" so as not to endanger the foetus. Some exploited the sick role in order to be excused chores and to be pampered, as Sophie explained: "I've always found it's a good excuse for doing nothing! Everybody does tend to pamper you. And you can sit there, and you just have to say, 'Oh, well, I'm tired,' you know, and that's an EXCELLENT excuse for not doing things."

The opposite of "feeling pregnant" was "feeling normal." When the women told me that they "just felt normal," they meant that the fact that they were carrying a baby had not impinged upon themselves or their lives in any significant way - they were, in fact, "carrying on as normal."

During pregnancy it seemed that these two self images, the pregnant and the normal, vied for ascendancy. The process by which the women came to see themselves as pregnant is described in the following section, but it is helpful here to outline the common pattern which emerged. At the onset of pregnancy the normal self image generally predominated because, as Anna put it, the women needed "a chance to believe" that they were pregnant. If they suffered from morning sickness during the first three months they were continually reminded that they were pregnant, with the result that they came to see themselves as expectant mothers. During the middle period, however, many women again tended to see themselves as normal, because then they had neither sickness, foetal movement or much weight gain to remind them of their condition. This was expressed when they said that they "forgot" they were pregnant. But by the end of the nine months enough 'signs' of pregnancy had accumulated to make it difficult for them to "forget" - and in addition by then their image of them-

selves as pregnant was continually being re-affirmed by others treating them as pregnant.

This was the most common pattern, but, of course, it did not apply to every woman. Joan, for example, seemed to see herself as normal during the whole of her pregnancy. This could have been because she was unhappy at being pregnant and so chose to sublimate her pregnancy by emphasising her normality. She gave an example of one way by which she did this : " I think I'm still normal, so I still do things like running about in the park and that, and having a wee game of football, and I don't think I shouldn't because I'm pregnant. I just think - although I'm pregnant, I still do it and I tell some of the girls, and they say 'Well, it's unusual for a pregnant woman to be running about like that.' "

Coming to see themselves as pregnant

The women knew that they were pregnant once their G.P. confirmed it. But they still had to learn to believe it and to regard themselves as pregnant. Judith illustrated this very nicely when she described her disappointment when, immediately upon hearing that she was pregnant, her mother-in-law bought her a cot. Judith felt unable to appear deeply grateful for it because she still needed time to adjust to her new self.

This section describes some of the ways the women took on their new identity. This could be a long and difficult process, because pregnancy is seen as a time of waiting (^{see} /for example the term 'expecting') which offers few bench-marks. There are few physical signs of pregnancy. One or two women never seemed fully to see themselves as pregnant. For example, Sheila said : " Sometimes it doesn't really hit you, either. Well, when I met my chum on Sunday, she says, 'What a size you are !' and I says, 'Oh ! I know I'm unsightly, and I know it's there. I can feel it kicking at times and

all this, but still ! ' I says, 'I'll not believe it 'till I see it ! ' I don't know. It's as if you're imagining yourself being pregnant at times." Burr has pointed out that the transition to parenthood is a particularly difficult one to make as the normative changes which occur are very involved both in number and in social significance (3). He has suggested that the adjustment in a role transition depends upon "the degree of importance attached to the change in the role." But as our society lacks clear procedures, the women found they had to fall back on their own ability to structure the transition. Ceremony can help the individual make the transition : " Ceremony helps the individual who is changing roles to appreciate that this is a critical moment ; for a little while it lifts him out of himself and helps him to feel as if he himself has changed in some way; this facilitates his psychological reorientation. Ceremonial also brings together a man's associates, and impresses on them that he has changed roles so that they are able to make a parallel reorientation " (4). But today ceremonial during pregnancy is fast disappearing; only christening seems to remain, and even that was losing popularity among my respondents. Churching the woman to purify her after she has given birth, which was formerly widespread in Britain, is now obsolete (5). Banton suggests that there is less public ceremonial attached to childbirth because the home is a smaller, more private place in industrial societies, and although having a baby involves the woman in a major role-change as regards her husband, her role does not change so noticeably vis-a-vis the community.

The process by which the women came to see themselves as pregnant

Passing

In the early days, when they were still fairly slim, several women 'passed'

and acted as though they were not pregnant. They did this partly in order to hold on to their sexually attractive selves for as long as possible. For example, at a wedding Anna deliberately wore a panty girdle. She was disappointed that the guests noticed that she was pregnant but complimented her sister, who was also pregnant, on her appearance. She told me that she wanted to tell them : " She's six months pregnant, you know ! " - and therefore in Anna's terms could not possibly be thought attractive. Another reason why someone might want to 'pass' is if his stigma relates to matters which cannot be appropriately divulged to strangers. Then, as Goffman (6) puts it, " a conflict between candour and seemliness will often be resolved in favour of the latter." Elspeth gave an example of this when she attended a party where she did not know the hostess and decided to pass as normal.

Announcing the pregnancy

Banton (7) has discussed the importance of announcements : " Often only by 'announcing' to others that they are assuming new obligations to each other can these obligations become fully meaningful to the parties themselves. This is a reminder that it is insufficient to persuade an individual that he is fit to play a new role, unless he knows he has the community sanction to do so."

In certain circumstances announcements can become problematic (8) and then interaction strategies to handle these issues become necessary. Women who were proud to be pregnant did not feel the announcement difficult to make; for them, pride cancelled out their embarrassment. But some women did find it difficult; these were the ones who saw it very much in sexual terms, and perhaps felt that they had not observed propriety in becoming pregnant when they did. Here their embarrassment hinged upon their implicit beliefs as to the 'right' length of time one should be married before having

children. Both Maggie and Wendy felt that they had not been married long enough, as Maggie explained: "Well, I did feel a bit shy, you know, at telling them. I don't know WHY, but - I just felt a bit shy at telling them, you know. I think it was maybe because I hadn't been married so long. And I think maybe it was because my sister, well, she was pregnant and THEN she was married, you know, and I always thought to myself I'll never get myself into that position. And I thought well, with not being married so long, people might THINK that about me. But then I thought well, I have been married over a year when I have the baby, so what is there to be shy about? It was just maybe the people about here would be counting their fingers, you know. People with nasty minds."

At the opposite extreme, Pat and Anna were embarrassed because they thought they had been married too long (three and four years respectively.) Anna told me she was embarrassed "incase they said, 'Thank God! After all this time. What happened?'"

The girls lacked skill in managing the information about their identity: "To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; in each case, to whom, how, when and where" (9). It was the "how" that often proved particularly difficult. In order to make the announcement some women felt they had to resort to verbal manoeuvres. Great store was set by being able to introduce the announcement "naturally" into the conversation. Elspeth deliberately let her husband tell her parents because she thought he possessed this skill: "Dougie told them both. I wanted him to tell them both! I chickened out. I sat there, 'Um, um,' (nonchalantly). I KNEW, as soon as my parents were coming, and before they came, I said to Dougie, 'You tell them,' because he's got a subtle way of talking about something and all of a sudden, he'll just put a remark in. You know - 'What?' He did it that way and

they never noticed! He sort of dropped a hint about something that my mother was talking about, when you stop work for your holidays and then you go back. She's a telephonist, and when she goes back she's a bit out of practice, you know. So Dougie says, 'Aha,' he says, 'Elsbeth will be finding that soon when she stops, now that she'll be stopped for a few years.' And they sort of went, 'Aha,' you know. So he turns round and says, 'She's pregnant.' -- 'Oh. Oh!'" As this shows, care had to be taken that subtlety did not vanish into obscurity.

Dougie's strategy exploited the fact that pregnancy entails change. When Helen tried to tell two friends she tried to do so by focusing their attention on the crucial cue of her thickening body: "Bob's got a slight beer pot. (He'd better not hear me say that). But you know, and they were saying, 'Oh, putting on the weight, eating too much,' you know. And they said something to me about they thought I looked slimmer, and I said, 'Well, I'm really sympathizing with him,' you know." But her cue was too vague, and her friends were left to puzzle out what she "really meant." The next time they saw her, they felt obliged to check their suspicion with her (again note the indirect language): "They said, 'Did you really mean what we were THINKING afterwards?' And I says, 'Yes.' They says, 'Oh, you ARE pregnant! We thought about it afterwards. We thought maybe that's what she means!'"

Certain groups seemed more difficult to tell than others. Prime among these were parents, children and male workmates. These were the groups with whom the women had difficulty in discussing sexual matters, and it seemed that when they thought of pregnancy in relationship to these people, the sexual overtones predominated, which left them feeling embarrassed. For example, Brenda was unable to be frank with her ten year old sister: "She doesn't know. We've never mentioned it to her. We just TALK

about it. I dinna think she KNOWS, really.... She thinks we're knitting for a friend. You know, when all the neighbours says they were going to start knitting, and hand them up to my Mum, she's trying to catch on - what was it all about? (giggles) And she says, 'What's that for?' 'Oh, your Auntie's having a bairn,' you know." The prospect of explaining the facts of life to her young sister seemed too enormous a task to Brenda. She justified her behaviour by claiming that, "You canna TELL her, because she just kind of laughs." And she rationalized it by persuading herself that "we want to give her a surprise, anyway." Elspeth and Anna hesitated to tell their workmates of their new status because they expected the men to play on its sexual nature. Anna said, "I wouldna have been able to say it to the boss or any of the men. Because, although they're married, they're always cracking wise-cracks, you know, wee bits of dirty jokes about pregnancy and sex and everything, that had I turned round and said I was pregnant, I would have been the centre of all the jokes."

All these difficulties were based on the sexual connotations of pregnancy. Other difficulties arose when the girls expected people to react unfavourably to the news of their pregnancy. Wendy had been friendly with a girl "who's very anti-children, and always going on about screaming brats and hating children, and always going to throw herself off Castle Bridge if she ever becomes pregnant." Wendy found it impossible to announce her news to this girl. Instead, she fell to making indirect comments: "When I was pregnant we were downstairs one day and we were chatting. And she said something about pregnant women and screaming brats; and I said, 'They're not ALL screaming brats, you know,' and I made one or two comments, and she didn't say anything. But I didn't say anything. I was quite friendly with her, and I used to chat to her a lot, but I couldn't bring myself to tell her, 'Oh, I'm pregnant,' because I felt that she would say, 'Oh, that's

super,' without really meaning it, and I just didn't want to hear her say it."

If they found it impossible to tell people some women let obvious cues 'tell' people for them. For example, Christine and Wendy ensured that their work mates knew by making it plain that they were attending the Ante-natal Clinic. Sometimes the husbands took over and made the announcements for them. Some did so because their wives asked them to, others because they were so pleased at the news that they could not restrain themselves. Their impetuous behaviour could embarrass their wives, as Pat found: "As we were walking up Glasgow Road that night we met his uncle Jock and I was quite surprised, because John's not one for speaking forward, but he says, 'You'd beter tell my Aunty Dora that Pat's pregnant, like.' And that was the first words that came out of his head. And I thought, God! Ken, I was quite surprised, he was really pleased with himself. I never thought he would tell anybody - but I couldna shut him up. A right wind bag. When we went up to Castletown, everybody we met, 'I'm going to be a Daddy.' Even his Dad says, 'God, look at that, you canna shut him up.' I says, 'Aye, I ken.' He says, 'He must be fair pleased.'" Perhaps the husbands had so little difficulty in announcing the pregnancy because to them it was a positive sign of their manhood (in that they had got their wives with child) which left no room for embarrassment. Wendy's expectation that her friend would have to react by treating her news as good news has far-reaching consequences. Friends' positive reactions played a large part in helping the women see themselves as pregnant. Burr (3) has pointed out that the degree of adjustment to roles varies directly with the extent to which the role permits individuals to realize dominant goals in their subcultural group; and Jacoby (10) and Newson and Newson (11) have suggested that the working class evaluate motherhood very highly. Therefore friends' pleasure and congrat-

ulations on hearing the announcement were probably instrumental in helping the women assume their new identity.

The role of others

There were other ways by which the group, in Berger's words, "conspires to bring about the metamorphosis" (12). Coser has suggested that, "Some roles are maintained through conformity to expectations concerning behaviour, others to conformity to expectations concerning attitudes" (13). When Jean's doctor told her she was pregnant she was acutely disappointed, but she felt obliged to dissemble to conform to what she believed was the "right" response (14). She told her doctor she was pleased she was pregnant "because I felt that if I said 'No' it wouldna do any good, anyway. If I turned round and said to Dr. Jamieson, 'No. I'm not pleased,' he couldna wave a magic wand or anything and say, 'Right, you're no pregnant.' So I thought, well, I'm just as well to accept it and say I'm pleased to people because if I went up and down with my face tripping me, and saying 'I'm no wanting it,' they'd say 'What a bitch she is, no wanting her own bairn !' ... So I just says I was. I didn't want him to worry and say 'Oh, I hope she doesna do anything daft, like trying to get rid of it,' because I wouldna have done that. If he had said to me, 'Are you wanting rid of it ?' (no that he would have said that, because it's not his job) and I'd have said 'Aye' Duncan would have killed me."

In some ways pregnancy is similar to a stigma. It can be seen as a physical deformity which prevents the woman from being as active as she usually is, and which marks her out from the rest of the company. As Goffman has suggested, the period during which a person learns he has a stigma is particularly interesting, in so far as this is the time that he is likely to be thrown into new relationships with others who also possess the stigma (15). This is how Jean described an early visit to the Antenatal Clinic : " When I was at the hospital, I was sitting one day and I

was looking at all the lassies walking past and I says, 'What am I sitting here for ?' And I says, just think, I'll go like that ... And now I says to myself, aye, I'm just like what I thought I wouldna have been." In Goffman's terms, Jean initially felt some ambivalence in accepting these women 'as her own', because she saw them as patently stigmatized, and not at all like the 'normal' woman she 'knew' herself to be.

On a less dramatic, but equally important level, the group continually reminded the women of their new identity by their conversation and behaviour. As Shibutani (14) has suggested, it is through social participation that perspectives shared in a group are internalized. Most women found that as pregnancy went on, conversation turned almost exclusively to pregnancy and motherhood. The Newsons (16) have noticed this : " Neighbours who have children begin to smile at her in a new way, and her slightest inquiry after the welfare of other babies will be warmly welcomed and eagerly encouraged. It is almost as if she has been admitted to membership of an exclusive club, the existence of which she had scarcely been aware of previously ... Even women of an older generation, whose children have long since grown up, will expect her to be interested in their own nostalgic reminiscences. In broader perspective, these subtle changes which the expectant mother experiences in her relationships with other people are probably a reflection of deeper and more pervasive cultural pressures through which society seeks to prepare a woman for the role of motherhood." For instance, by eight months, Pat was thoroughly tired of hearing about other women's pregnancies. She said : " But see when you're pregnant, that's everybody's subject. I mean, even if you meet somebody, say if I went to the Bingo : 'How are you feeling ? Oh I mind when I was pregnant,' and then they go on about their bairns and everything. I thought, God, can somebody no speak about something different ? ... It'd be nice for

somebody to sort of speak and say that you've no got a lump sitting in front of you ! "

When other people behaved solicitously towards them, they were encouraging the women to see themselves as pregnant, in that, as Berger says, "we become that as which we are addressed".⁽¹⁷⁾ Joan described the following incident :
" I was in a restaurant the other day, and the woman was serving me, and I was perfectly alright. And I was wondering what was wrong with her - she kept on saying 'Do you want a glass of water ?' I thought 'What's wrong with her ?' And then it dawned on me that it was because she knew I was pregnant." And by constantly advising them how to behave, friends could reinforce the pregnant self.

Physical cues

A central reason why the girls had difficulty in seeing themselves as pregnant was that they believed that there were few identifiable 'signs' or cues of pregnancy. Kathleen explained this very clearly : " So far, you KNOW that you're expecting, but there's not many SIGNS, really. Well, you go through morning sickness, but it's all sort of taken for granted, like. Well, when you fall pregnant, the first thing somebody says to you is, 'Oh, morning sickness ! ' and that. And when that's over, for a wee while there's nothing really. And then you sort of feel the baby move and that." As I explained in the section on self-image, the main signs were sickness, gaining weight and feeling life. Sophie described how she regarded the cessation of sickness as a transition stage or milestone : " Most of the time you're completely detached from it. You KNOW you're pregnant, and after the sickness bit sort of disappears, and in between putting on weight, you feel so normal that you tend to think, well, I'm not really pregnant after all. You just forget about it." Because of this, some women found it easier to believe that they were pregnant during the early months,

when they were suffering from morning sickness, than during the middle months when there was no physical 'symptom'. The implications of gaining weight will be discussed fully in the next chapter. Julie had difficulty in believing she was pregnant " because I'm still, you know, quite slim. Oh, you can't even tell, you know. But perhaps when I get like this (sticks stomach out) I'll think I am !" By eight months Ruth's body had become a constant reminder that she was pregnant : " You can't forget it, because, I mean, your BUMP'S there, and as I say, you maybe stand close to something - and you don't realise you're as close ! And maybe if you're pressing against something, you feel the baby moving more then. So I don't think you COULD forget. Maybe if you hadn't too much of a bump ! Some people have said to me 'I never think about being pregnant.' But maybe I look at them and say 'Well, you've nothing to show for it.'"

Some women regarded the first kick as a stage transition. Kathleen said, " Before, you didn't really think anything, you know ; you didn't think there was really something there. And then when you feel it moving, you think 'There's something there', you know, and it's alive and it's moving, you know, and it's a funny feeling ... I think that's the first sign, when you know it's - when you FEEL it's alive and moving, that you've no got long to go ! Really, I think it's the first sign from when you get the news. This is the sort of next step, really."

Props

Props can be important as a means of setting the scene and helping the actor believe in his part (18). During pregnancy, baby clothes and equipment can become significant props, as Gina showed : " I think it's just when you start to BUY things, you know, nappies and baby-grows. And people start knitting things and giving them to you, and you say 'Oh that's for my baby. Oh that's for my baby. Oh I definitely AM having a baby, you know.'"

Learning how to behave

Once they were pregnant, the women had to learn what was appropriate behaviour. (They called this 'adjusting'.) A large part of this was learning that physical exertion must be limited, and they learnt this mainly through the advice of others and through trial and error. When she was seven months pregnant, Maggie found out the hard way that she was not able to walk as far as she used to. After spending the day walking about the town, in the evening against her mother's advice she set out to visit her father in hospital : " My mother says 'Oh, you shouldna walk so far ! ' I says 'Oh, but I'm alright', I says, 'I'm only pregnant, I'm no ill.' She says, 'I ken,' she says, 'But your legs', she says, 'You dinna realise the weight that you're carrying. You're carrying a lot more weight than what you usually carry, and your legs get tired more easily.'" To her dismay, Maggie soon discovered that her mother was right : " And I went into the town, and I was walking along to the hospital, and I felt as if I could just have sat down in the middle of the street, my legs were that sore. And I felt terrible. And I suffered that night with them, because my legs - you know how when you were young you used to think they were growing pains ? Well, THESE kinds of pains. I think it's tramp or something. But oh, it was terrible, the pains in my legs. I'll never do THAT again! "

Similarly, certain types of behaviour were no longer permissible. For instance, Jean told me : " See one night, Duncan came into the bedroom, and jumped on top of me. (giggles) He jumped over the bed, because he used to always scare me. He used to put the light off in the bedroom, and then crawl round the bed on the floor, and he'd jump up and go 'WHOOOO!' like this. And he done THAT one night, and he put his hands just there (on her stomach) ken, and he come 'WHOOOO!' like that, and I says 'Watch that bairn, you!' He says, 'Oh, I forgot all about it.' I says, 'How can you forget about

that ?' And he says , 'Because I did.' he says, 'I keep forgetting you're expecting.'"

Benchmarks

Because the women felt that there was a lack of clear, societal procedures, as well as so few signs of pregnancy, they tended to invent their own benchmarks as an aid in structuring the time and in coming to see themselves as pregnant. Several of these benchmarks centred on the hospital appointments. For example, Sophie saw her visit to the Booking Clinic as an early benchmark : " I was looking forward to the Booking Clinic, mainly because I thought, well, once THAT'S over, I'll feel as if I really AM pregnant, you know, and everything's arranged. You know, that's one big step over." Sheena told me she was looking forward to returning to the hospital Clinic at thirty-two weeks because, " I know when I go back I've not really got long to go." Helen saw admission to hospital as an important benchmark because, " then I know, well, that's it, the baby'll soon be here." (Her perception of admission as a benchmark also served as a coping mechanism with her anxiety about going into hospital.) Finishing work was another popular benchmark. Illustrative of the lack of benchmarks was the fact that Sheila even used me as one ! She told me, " That was like when you met me the last time, I says, 'I look forward to seeing you then, because I won't have long to go.' And I says to him yesterday, 'There's that girl coming tomorrow', I says, 'And that's it.' It seems AGES, you know, but it's come round pretty quick."

Beliefs which hindered the women from seeing themselves as pregnant

Implicit in some women's attitudes towards pregnancy were certain beliefs which hindered their realisation that they were pregnant. Sophie, for example, believed that it was bad to become " too preoccupied " with pregnancy " and let it rule your life ". She based this on her belief

that " There's more to life than being a mother, or just being a housewife or whatever. And I don't think it's good to become sort of FANATICAL or become too DEPENDENT on just one thing or one person, or whatever ...

I think you ought to keep an open mind and enjoy things as they ARE." In this way she justified feeling " completely detached " from her pregnancy and forgetting about it for long periods of time.

Similarly, Jean told me " I think you're better off if you forget you're pregnant." She said she reached this conclusion after finding out that she felt better for being active. However, her belief could also well have been related to her dislike of pregnancy in that forgetting she was pregnant was a temporary way of dealing with the problem pregnancy posed for her, because she came to use her conviction that she felt healthier after being active as a justification for suppressing her pregnant self.

Forgetting that they were pregnant was also a way that some women coped with their anxiety about their foetus. Wendy used this technique very heavily during the announcement period, when she was slow to tell people in case " anything happened " and she had to face the pain of retracting her announcement. Christine deliberately stopped herself from dwelling on her pregnancy, getting excited about the baby or buying baby things because she believed that " it's always at the back of my mind that something might happen ". Her fears were accentuated by learning that her friend's sister lost her baby at seven months. In these ways the women's beliefs about the nature of pregnancy worked to delay them from assuming their new identity.

This section has described some of the ways by which the women came to see themselves as pregnant. This process is a long and gradual one, as pregnancy is mainly seen as a time of waiting, which offers few inherent benchmarks.

The divesting of the sexual self

As their pregnancy progressed, all the women, with the notable exception of Sophie, gradually divested themselves of their sexual identity. They generally repossessed themselves of it at some point after the birth. As this section shows, whether a woman saw herself as 'sexy' or not was closely linked to how attractive she felt her appearance was. The section begins by discussing how the women defined an attractive appearance. It goes on to give evidence for the existence of the divesting/repossessing cycle of sexuality, before showing why the women felt themselves to be unattractive.

All societies have their own ideas as to what constitutes a 'sexy' body. If we adopt a Durkheimian model (19), we assume that members of a society share certain attitudes towards, and understanding of the human body, and that there is a communally shared knowledge of how a 'beautiful' or 'erotic' body is defined. Furthermore, each section of that society, whilst broadly accepting the overall societal definitions, will probably differ somewhat as to the exact type of body it admires. My women's images of normal and sexy bodies are discussed at length at the end of the next chapter, but, briefly, to them a 'sexy' body was one which was slim, well-shaped and in proportion, and fashionably dressed. They laid great stress upon the figure, and so it followed that the more pregnant they looked, the less sexually attractive they would feel. And, because their sexual self image was bound up with how attractive they felt they looked, as they got fatter, they necessarily gradually divested themselves of their sexuality. Their phrases, "losing their figure" and "letting themselves go" were synonymous with losing their sexual appeal, at least in their eyes; once the women looked pregnant they believed that men would cease to find them

sexually attractive.

Judith's comments illustrated the importance a slim figure played in being sexy. The key phrase here is "wait 'till I get slim again". "One day Alastair and I went to the Zoo, and I wasn't particularly in a very good mood, and er there was this girl in front of us. Now Alastair doesn't - now, EVERY man LOOKS, there's no question about that, but Alastair doesn't obviously look, unless I'm nagging, you know ! THEN he makes a fuss. And there was this girl in front, and she had trousers on, you know, and she was sort of wiggling along the road, and he DEFINITELY had a look, you know. And I sort of, well, I laughed, and I said, 'I've seen you.' He says, 'What ?' I was really annoyed, you know. (laughs) I thought, what a pig you are! (laughter) I thought, wait 'till I get slim again, and I'll wiggle my back-side !" Judith clearly felt that her husband had taken unfair advantage of her. Both of them 'knew' that she could not compete with the girl in the sexual stakes, as her eight-month pregnant body rendered her 'out of play'.

The women used a number of terms to describe a pleasing appearance. These included : nice, feminine, sexy, glamorous, elegant, smart, neat, immaculate, appealing and alluring. And these words had different nuances or symbolic significance. 'Sexy' was not a common term, and maybe it is more of a middle-class term. Only Judith, herself one of the more middle-class of the women, used it. 'Smart', 'neat' and 'immaculate' (and sometimes 'nice') seemed to mean that the woman was presentable in a neat and tidy sort of way. 'Smart' also implied fashionable and 'neat' often meant that a woman was not overweight, (as when Christine's friends reassured her that, despite her father-in-law's jokes, she really was "quite neat".) These words did not carry strong sexual overtones. 'Glamorous' and 'elegant', however, hinted at eye-catching, sophisticated dressing, and it may be that, to some

extent, 'glamorous' is a working-class euphemism for 'sexy' (see the plethora of Glamorous Grandmother competitions at working-class holiday camps.) From the contexts in which they were used 'feminine' and particularly 'appealing' and 'alluring' had sexual overtones. 'Feminine' was used in conjunction with scanty, frilly underwear, backless dresses and parties, whilst 'appealing' and 'alluring' were used as direct synonyms for 'sexy'. 'Nice' was a more general term, but could carry mild sexual overtones, as when Elspeth said that men whistled at women who were 'nice', and Pat talked of wanting to look 'nice' in front of men.

In fact, it seemed that many of these women were very aware of men in the way they dressed. They were less concerned at looking unbecoming before women, but they wanted to look their best in front of men (20). This explained why Pat saw the Bingo Hall as the pregnant woman's 'retreat': "Ken, I went to the Bingo before I was pregnant, just now and again. And I looked round, and it was all a lot of young lassies that were pregnant. This must be the retreat! (laughs) That's what it's like, the retreat, go to the Bingo. Because it gets you out, and it gets you into company. But it's no as if you're going into a pub, when you've got to go - well, I like to go NICE - and you're meeting other company and that. You're still meeting company, but it's mostly women."

The crucial difference here was that in a pub, Pat would have been mixing with men. In the Bingo Hall she met only other women. Therefore at Bingo there was no need for Pat to try and appear attractive, which was precisely why it had become the 'retreat'. Her comments showed that if she knew men would be present, Pat would dress with them in mind - that is, attractively ("I like to go NICE").

If one sees pregnancy and childbirth as representing the fruits of a woman's femininity and sexuality, the fact that the women felt they relin-

quished their sexual identity during pregnancy may at first seem paradoxical. The link between pregnancy and sexual activity is an obvious one, and Anna for one was very aware of the sexual overtones of pregnancy. For example, she told me that when she was in hospital some of the patients had been teasing a young nurse about her "heavy" date, and she added, "But what were WE all doing? We had just had a BAIRN, you know. We were all in the MATERNITY ward. Listen to all the wee pure ones, you know, talking to her!" But it may be more accurate to say that our society perceives sexuality (in terms of what is sexy) in terms of sexually stimulating appearances and behaviour. Certainly my women tended more towards this view. It seems that society allows only individuals who possess certain qualities to act in certain ways. Bennett (21) understood this very well when he described the disgust Sophia felt at encountering the elderly and obese Mme. Foucault abandoning herself to the grief of unrequited love: "At first glance the creature abandoned to grief made a striking and romantic picture ... There was, in the distance, something imposing and sensational about the prone, trembling figure. The tragic works of love were therein apparently manifest, in a sort of dignified beauty. But when Sophia bent over Mme. Foucault, and touched her flabbiness, this illusion at once vanished, and instead of being dramatically pathetic the woman was ridiculous. Her face could not support the ideal of inspection; it was horrible; not a picture, but a palette ... Then she was amazingly fat; her flesh seemed to be escaping at all ends from a corset strained to the utmost limit. As a woman of between forty and fifty, the obese sepulchre of a dead, vulgar beauty, she had no right to passions and tears and homage ... It was silly, it was disgraceful. She ought to have known that only youth and slimness have the right to appeal to the feelings by indecent abandonment" (22). Similarly, it could be that we only allow the young, the good-looking and

the slim to be sexually attractive and behave in a sexual way. Perhaps all attractive women are potentially eligible sexual partners, but pregnant women become temporarily ineligible once they have lost their figures. (As Pat put it, "You cannot look NICE when you're pregnant.") Lynne Reid Banks (23) implied this when she wrote, "I nearly giggled at the idea of anyone trying to pick up a girl as pregnant as I was." This analysis gains support from the later section on misrepresenting identity, which describes how Judith and her married girlfriends were 'chatted up' in a pub. The assumptions here were that Judith, being pregnant, was really an ineligible partner, but that her married friends were not. There is also support for this analysis in the literature. ^{although dealing with a lower working class sample including some multiparae,} McKinlay (24), for example, found that although his women did not express any embarrassment during their ante-natal care, they found their post-natal examination embarrassing. In suggesting that the women redefined the examinations once they returned to 'normal physical function and appearance', he was implicitly saying that women lose their sexuality when they are pregnant. As Chapter Seven shows, my data suggests that the situation is a little more subtle than this. It seems that the divesting process is a gradual one throughout pregnancy, and that this was shown by the fact that my women were embarrassed during their ante-natal care (25). However, I think McKinlay was broadly correct in suggesting that women do not see themselves as sexual beings during their pregnancy.

This desexualization process culminated at the birth, although even up until then some women retained vestiges of their former sexual selves. Once their babies had been born, most women felt that they soon regained their sexuality. This cycle of divesting and repossessing sexual identity was well illustrated by Jean. During her second interview, she was quick to tell me how embarrassed she was by masculine attention: "And what I

hated was the young chaps out in the street,whistling at you. And they would then look again,and say,'Oh!' ken. That's what used to embarrass me. That's what I hated. Well,they didna realise at first,and when they got closer to you and they noticed,they says 'Oh !' ken. One of the foremen gave them a row one day for that,whistling at me. He says,'Can you no see the lassie's in the family way ?' And their faces went red,and so did mine." She explained that she would not have felt the same if she had not been pregnant : " Different if somebody whistled at YOU,you wouldna bother yourself,you'd take it as a compliment. But when you realise you're EXPECTING,you feel different about it." She believed that the men whistled because " they think that you're single. Then when they see THAT,well, that puts an end to it." Therefore,Jean felt embarrassed at the men's discovering her ineligibility.

In the third interview she offered another reason : " Well,it's a bit embarrassing because they - the ones that whistle - they didna realise I was pregnant because they were whistling as I was walking past them from the back,and when they saw my stomach,they used to look and laugh. And THAT'S what was embarrassing. Like they would be saying,'Oh,I ken what YOU've been doing.' Ken what I mean,that sort of feeling. If you're walking along the street and they dinna see your wedding ring,they dinna ken anything about you. But I used to feel,oh,they'll be saying,'I ken what you've been doing.' Like a wee laddie said that to my sister one day - 'I ken what you've been doing,Missus.' He was only twelve,too,and her man ran after him. And that stuck in my head when she telled me about that. Every time fellows used to whistle and then laugh,I used to say to myself, oh,they'll be saying,'I ken what you've been up to.' So I was sort of embarrassed about that."

So Jean was embarrassed both by confusion as to her eligibility and by

the relationship between pregnancy and intercourse. If it had been merely her incipient motherhood which upset her, she would still have been embarrassed when men whistled at her as she was pushing the pram. But she was not. Instead, in the third interview she told me that she enjoyed hearing men whistle at her. In these encounters with men, body image was considered to be much more crucial than the fact that she was a wife or mother. As she said, "Fellas dinna worry if you've got bairns or no."

Judith also exposed her assumption that pregnancy was a desexualization process when she described how she felt when Alastair reacted towards her as a mother. During her early months his behaviour irritated her, but once she had lost her figure it failed to annoy her. She said, "It did, perhaps, at first, but not now because I feel - I don't feel the least bit sexy or - you know, alluring in any way (laughs). So, no it doesn't bother me. I'm quite happy that he thinks of me like that ! Well, when I look at myself in the mirror, I think, 'Well, who could feel sexy with that ?'"

When I asked women if they thought that pregnant women could be 'sexy', I was usually met by incredulity and laughter. For example, Pat replied, "Oh!" (bursts into laughter) What, you mean appealing ? Oh, anything but ! Oh, I think they look repulsive - oh, no. I dinna think so. Oh, no. (giggles) If it was a nice young thing walking along all slim and a nice dress and all smart and that, you could say aye, but no somebody plodding along ... No, there's nothing nice about it. Not a thing."

Her answer showed her image of 'sexy' ("nice young thing ... all slim ... a nice dress ... all smart.") It also highlighted some of the reasons why the women felt unattractive. Firstly, they had assimilated society's current dictum that slim is beautiful and fat is ugly (26). During her first interview, Pat said, "I've said to John, 'Am I looking too fat ?' He says, 'God, you can hardly notice it.' I says, 'But I feel really fat within myself.'"

Because I was a twenty three or a twenty four inch waist, and it's about thirty two now. And I KNOW - I mean, I look fat and I feel fat. And I says, 'Are you sure?' I'm awfully self-conscious of being fat. I think I've been thin that long. I like being thin and I dinna like being fat. Oh, God, anything but I hate to see great fat podgy people." Many girls felt unattractive because they equated being pregnant with being fat. Our society does not seem to differentiate very clearly between a woman who is gaining weight and one who is putting on weight to have a baby. We do not even have a term which refers to the weight a woman gains when she is pregnant. It seemed that it was only with an effort that some of them reminded themselves that they were "not really fat," but pregnant. For example, the first thing Jean said when I saw her for the second time was, "I think I've got right FAT now. I think I've went enormous." Later she described how her husband disliked fat women but accepted her size because "it's the bairn, you see, and he loves that bairn." She clung to this way of seeing her body, but not without difficulty: "(I see) the same thing. I dinna think it's ugly either, I think it looks alright. But as I say, I'll be glad to get rid of it. As soon as I've had the bairn I'm going on a diet."

Pat told me that one reason why she disliked her shape was that it was out of proportion. Thus the pregnant figure tended to be seen as fat, unattractive and even abnormal ("Oh no, it's anything but normal. Well, it's NORMAL, but it looks anything but normal.")

Some women also complained of feeling clumsy and ungainly. Looking back on her pregnancy, Elspeth said that at the end she was very big. She felt that pregnant women might look quite "nice", but "I don't think latterly themselves they feel it, because they feel so cumbersome. You try and get past something, and you think 'Oh, I can't'. And also your hands are swollen,

and your FEET and your ankles are swollen. (to the baby) What a trouble you were !"

One horror they had was that they might waddle. This was seen as the height of ugliness, and a woman who waddled was not regarded as feminine. Waddling prevented her from looking smart. Helen said, "The thing I always try to avoid was, I used to see an awful lot of pregnant women, they're very fat and they used to waddle. And I keep saying to Bob, 'I hope I've not got that pregnant waddle yet.'"

Anna described how her size stopped her from sitting in a pretty, lady-like way : "You know, you're no very comfortable. You've got to sit with your legs open all the time. You know, I mean, it's terrible sitting on the bus. It's alright if you've got trousers on and you're sitting in a wee seat, you can sit with your legs open and it IS comfortable. It's no VULGAR or that, but it's the only comfortable way you CAN sit. Well, you canna sit with your legs crossed or anything, trying to look all pert and dainty like."

Therefore, throughout their pregnancy, the women came to see themselves as fat, clumsy and unattractive. They felt their walk became graceless and lumbering, and they were forced to sit in awkward, 'common' positions. Because the girls did not perceive these attributes as sexually attractive, they contributed towards the women's loss of sexual identity.

A sexually attractive appearance is very bound up with the clothes one wears. When they were pregnant the women felt restricted as to the sort of clothes they could wear, and this had at least three ramifications. The first was that because they believed that fashionable clothes depended on a slim body, they felt unable to wear them. Sophie underlined this when she said she felt that there was "nothing nicer than a slim, trim figure" which enabled one to wear "all these nice, trendy clothes."

Secondly, they could not have many changes of clothes. Many girls felt that this undermined their attractive selves because, to them, looking attractive depended upon having a large variety of outfits. (As Pat said, "I'm all for new clothes and wardrobes - I'll no get that now right enough !") This belief had repercussions upon their social life, as will be seen in a later part of this chapter. The women felt obliged to wear the same clothes all the time, because they felt that it was too expensive to buy many clothes in their new sizes as these would not fit once their figures returned to 'normal'. As Helen said, "But you don't want to go and buy a whole wardrobe of MATERNITY clothes because it's a waste of money REALLY, because it's only for a short period. Only unless you're having another child soon after would you get any use of them." Considering the short life-span of maternity clothes, they were seen as prohibitively expensive. If a woman was gaining weight very rapidly, some clothes might last only a few weeks before they had to be abandoned and she was back where she started with "nothing to wear". Jean's experience had an almost 'Alice in Wonderland' quality about it. After managing to wear her size ten clothes during her early months, she found that when she reached the middle of her pregnancy, she put on weight very quickly. Suddenly she found that none of her clothes fitted her : "And I says to him, 'How am I supposed to go out of the house ?', I says, 'I'm bloody fed up.' I says, 'I canna get clothes to fit me.'" Her husband encouraged her to go out and buy more. "And so I went out and bought another frock. I got size twelve, and I had it about three weeks and IT was too tight. I got a thirty-four brassiere, and it was cutting me - I only had it on for a week, too - and I seemed to get bigger and bigger, and I says, 'For goodness' sake, when am I going to stop ?' Ken, I went away and got they other dresses, and they're just MANAGING to fit me now. I can see me going out again (to buy some-

thing else) before I've had it. And that's no fair because I've only got four weeks to go !"

Women like Helen were reluctant to go out and buy more, so they had to manage as best they could in clothes they knew were ill-fitting. She told me, "I've got a pinafore thing, and it's not as full as this one is, and when I wear it I seem to sort of bulge at the back, and I'm reluctant if I'm out somewhere to take my coat off, because I feel unsightly, you know ... Well, to stand up, anyway. It's alright the front view, but stand up and you seem to be bulging a bit at the back and the front, and you look a peculiar shape, you know. Pregnant duck, or something." The 'pregnant duck' image was far removed from the 'sexy' body with its slim, well-proportioned figure. Consequently, many of the women developed a dowdy, boring body image. Shiela described this feelingly : "When you go out on a bus or anything, you look at everybody and people come on and they're all dressed up and all glamorous and everything, and you're sitting there, and you're sickened of yourself in the same coat. You feel terrible."

In addition, few of them regarded the clothes they could wear as flattering. Several told me how ugly and limited maternity clothes were (27). More significantly, given their belief that looking 'sexy' was bound up with looking young and fashionable, they felt maternity clothes were old-fashioned or "for an older person".

But even if they avoided the horrors of maternity wear, they were still faced with ugly underwear. Women like Judith, Elspeth and Pat were very particular about their underwear. They liked frilly, fancy underwear ('nice things'), which they saw as feminine and 'sexy', and so it was not surprising that they hated the big maternity underwear they were now obliged to buy. Judith said "I'm looking forward to wearing dainty underwear, instead of great big knickers, and things like this, you know! That's

what I'm looking forward to. You know, being sort of, well, FEMININE again - fluttery feminine, instead of --" (tails off.) Here Judith was implying that she could not feel attractive in large knickers.

There is a popular saying that a woman's looks improve when she is pregnant. The "You and Your Baby" booklet given out at some of the hospitals says, "One final point about how you feel in these early stages of pregnancy. Most women feel splendidly well and they look it. There's quite often an improvement in the health of the skin and hair. One of my colleagues says that with women he knows well, he can often guess at pregnancy just by the improvement in their hair. Any experienced hair-dresser gets to know this too. So that is a bonus of pregnancy."

The booklet also prints a poem called "The Beautiful" which describes one of the three most beautiful things "that any man could wish to see" as "a woman, young and fair, showing her child before it is born." My women expressed this idea that they should look radiant by the term "bloom." One or two women, like Ruth, expected to "bloom," but most of them felt that they did not. For instance, Elspeth told me that in the early part of her pregnancy she had looked "terrible, all white and drawn, and eyes sprouting out of my head."

It seemed that the booklet and the women had different definitions of beauty. To the booklet, beauty was a young woman in good physical condition, radiant with the happiness of carrying her child. Significantly, only Ruth shared this definition (28). But to the rest of the women, beauty was a slim, well-proportioned body which they believed men would find attractive. Their definition stressed the erotic more than the writer of the booklet had done, with the result that no amount of "blooming" would have repossessed them of their sexuality. As Pat put it, "You're supposed to look beautiful - I think you look bloody awful! I was reading this poem.

I was getting my kill at it too. You're supposed to look beautiful, and people think you're radiant and all the rest of it. And I thought oh my God, whoever wrote that must have been nuts."

The Effect of their Body Image upon their Behaviour

In "Gulliver's Travels" (29), Swift discussed the traditional view of man as a limited creature in whom mind and body are at odds and must (as far as possible) be reconciled. The body as well as the mind is always oppressively present, the mind always caught in the miniscule Lilliputian or the clumsy Brobdingnagian bodies, and in each case obviously and inescapably influenced by the body in which it lives. The effect of the physical accident of size on the mind is clear. The Lilliputian mind was precise, petty and limited, just like their vision. Generosity and gratitude make way for cruelty, neatness and efficiency. Among the Lilliputians Gulliver was at his most attractive. But when he found himself a midget among the giants he became like a Lilliputian - his former magnanimity lost, his pompous behaviour absurd.

Swift was expressing an important insight here: that body image affects behaviour, where body image means the visual picture an actor has of his appearance (30). That is, as the discussion of eligibility in the previous section showed, actors build up images of the types of people who can engage in certain activities (for example, handsome, dashing, charming men can be Don Juans.) And secondly, people build up pictures of themselves. Sherif (31) has written: "Self is a developmental formation in the psychological make-up of the individual, consisting of interrelated attitudes that the individual has acquired in relation to his own body and its parts, to his capacities, and to objects, persons, families, groups ... Defining, as they do, the individual's identity relative to objects, persons,

groups and situations around him, these self attitudes determine the individual's experience as an active agent, principal actor or executor when they participate in ongoing psychological activity."

Armed with these complementary images, the actor can then feel either encouraged to act in a certain way (if he feels his appearance is 'up to it'), or discouraged from such behaviour (if he feels his appearance cannot sustain it). It was therefore not surprising to find that the women's behaviour changed as their body image changed. The areas which were most affected were their interaction with men and their social life. There were three main aspects here. The first was that as the women no longer saw themselves as sexual beings, they no longer felt able to act in a way which they considered 'sexy'. This explained why Judith, at eight months, felt unable to compete with the girl who was "wiggling her backside" outside the zoo, or to wear a sexy black dress and act in a provocative manner before her husband (32).

It seemed that there was no uniform agreement as to the sort of social life a pregnant woman should lead. However, the image a woman had of her body certainly affected her social life. In order to understand the dilemma that social life could pose, two basic assumptions should first be stated. The first was that in order to enjoy herself fully when she went out, a woman had to believe that she looked "nice". The second was that she had to feel able to throw herself into all the dancing, drinking and eating that made up the social whirl. However, over-indulgence in these activities was widely considered to be bad for pregnant women. Jean summed up both these assumptions when she said, "We didnâ go out much when I was pregnant because I didnâ LIKE to go out. You canna get dressed the same, and you dinna want to go out, you canna be bothered. You canna drink or anything." Added to these basic assumptions were other, more individual beliefs as to

the sort of behaviour which was considered seemly.

By the time she was eight months pregnant, Elspeth was longing to regain her figure and "start feeling human again". When she explained that by "human" she meant feminine, she was clearly saying that she felt she had relinquished her sexual identity. She told me, "We've never gone out as much as we have recently, you know, to a lot of parties, and there's women in backless DRESSES ! Oh ! (laughter) And me sitting, my arms away out in front of me." Because she believed that she was no longer a potentially eligible sexual partner, Elspeth felt unable to wear anything as overtly sexy as a backless dress. She gave this as one of the reasons why she did not want to go to parties : "It's NOW, in the last few weeks, I think you tend to feel, I can't be bothered doing ANYTHING much. Mixing with people, you know. It's alright having friends in, or going to friends' houses, but not going OUT. Like to a party or a dance. ESPECIALLY when you see all the other females all dressed up in nice dresses and you can't wear them !" I have already suggested that there are similarities between being pregnant and bearing a stigma. Whether or not being pregnant is wholeheartedly perceived as a stigma depends on the meaning the actors give the 'bump'. Goffman has suggested that when a stigma is immediately noticeable a crucial issue is how far it interferes with the flow of interaction (33). This suggests another reason why Elspeth began to find parties less enjoyable as her pregnancy wore on. In describing how, at six months, she had danced with someone who did not know she was pregnant, she favourably compared his behaviour with that of other partners who were irritatingly aware of her condition : "I'd been up dancing with some of the other guys, but they were all friends of Dougie's, and they KNEW. And it was quite good, because most of THEM were saying, 'Are you feeling O.K.?' and things like this. And a few of them were saying, 'Are you sure you can

dance ? Is it alright to dance ?' 'YES !' (through bared teeth) Well, this guy didn't know, and it was quite good, right enough, because we were just CHATTING (said in tones of relief). It made me think, oh, that's good."

As we have seen, most of the girls believed that it was important to have new clothes in order to look attractive, especially if they were going " somewhere special ". It was because Kathleen felt it was extravagant to buy a new dress when she was eight months that she refused to go to her friend's twenty-first birthday party. As she explained, " I mean, I couldn't go in something that you'd been wearing for about four months every day. Doing the housework in, you know ! "

Pamela was single when she became pregnant. She was seventeen and living in a flat with a girl-friend. Up until that time, dancing had formed an important part of her life, but once she conceived, it suddenly became much less enjoyable : " Well, we used to go out all the time, you know. And I just didn't feel like going to the dancing after I found out. I went to the dancing once, but I just didn't enjoy myself, because I knew the baby was inside me. And I couldn't have such a carry-on as I used to have. It just wasn't the same." As she had not gained any weight at that time, Pamela's dissatisfaction with dancing could not have been a result of her body image. Rather it was probably derived from two other factors. The first was that the foetus was always very real to Pamela, a fact which could well have heightened her anxiety that strenuous activity might harm the baby. The second was that she saw dancing in sexual terms. In her milieu, dancing was the accepted way for a single girl to meet men. But after she became pregnant, dancing lost its point, perhaps because she believed it was improper behaviour for an expectant mother, and perhaps because she now saw herself as an undesirable partner for a man - pregnant with another man's child. (This is developed in the section on misrepresenting identity.)

The term she used, "carry on", encompasses both these meanings. Therefore, as their pregnancy wore on, the women increasingly stayed at home. Sometimes their husbands went out without them, and then life for their wives became lonely, tedious or fraught with anxiety or jealousy. Much clearly depended upon the type of marital relationship, and in particular upon how far they felt able to trust their husbands. Pamela, for example, married after she became pregnant and living with her parents, found the last three months an extremely wearing and depressing period, as she believed that her husband was flirting with other women.

A few women did feel able to go out, even at the end of their time, and it is interesting to ask why they felt able to do so, and what reaction their behaviour elicited. Goffman (34) has said that "we normals develop conceptions, whether objectively grounded or not, as to the sphere of life-activity for which an individual's particular stigma primarily disqualifies him." Maggie's sister-in-law, for one, had defined a "sphere of life-activity" for pregnant women which did not include dancing. Maggie told me: "Everybody'll say to me, 'How can you go out when you're like that?' My sister-in-law, when we had our anniversary a couple of weeks ago, you know, we went for a drink and that, and there's a dance hall where we went. And I was up dancing. And she says to me, 'You've got a right brass neck, going up and dancing like that.' And I says to her, 'How have I?' She says, 'Imagine going up in that condition and dancing!' I says, 'I'm no different from anyone else. I'm only pregnant ... I don't care.' I says, 'It doesn't bother me', I says, 'Folk can look', I says, 'Everybody knows I'm pregnant.' I says, 'You can tell that by looking. Nobody'll make any difference if I get up and DANCE.'"

Maggie and her sister-in-law seemed to give different meanings to dancing. Banton (35) suggests that, "Dancing is not an activity separable from

other relationships: it is full of implications for other relationships between the parties in which sexual roles will be important." Like Banton, the sister-in-law seemed to see dancing very much as an activity in which sexual roles were important. She probably saw it as an opportunity for a woman to display her body. As she deplored the fact that Maggie had gained so much weight it is probable that, as Maggie guessed, she felt she was making herself look foolish in showing off her unattractive body. Therefore, to the sister-in-law dancing was forbidden because it involved sexual roles which an obviously pregnant woman could not fulfil. However Maggie herself belittled the significance of dancing ("I'm only getting up and having a wee dance"), and emphasized the fact that she was still normal ("Why should I feel any different?") Her attitude was that her identity was clear to all ("everybody knows I'm pregnant"), and so, as she was not misrepresenting herself as a sexual woman, her dancing was permissible.

Ruth's experience illustrated the uncertainty some women felt as to whether they could enjoy a social life. She was eager to have a baby and was proud of her body. However, she had internalized society's dislike of the fat body in so far as she believed that her body could only get so big before it became an embarrassment to her. Her husband's positive attitude was instrumental in persuading her that her body was not an embarrassment and she could go out. She said, "I went to the dancing the Friday night after he was due. And I said to my husband, 'Are you embarrassed taking me out like this?' Because I was really - I had on a wee pinafore and it came to here, and I was sticking out like this. I was enormous. He says, 'No!' he says. 'Don't be daft. It was me who put you like that. I'm PROUD of you like that.' He loved to see me like that. And he took me round the dance and introduced me to everybody."

In conclusion, because they divested themselves of their sexual identity during pregnancy, that part of their social life which included contact with men and involved them in appearing sexually attractive (for example, going to parties and the pub) became problematic. Dancing, with its more obvious sexual overtones, posed particularly difficult problems (36). Because there were no universally accepted norms of behaviour, different people had different definitions of what was permissible and what was not; and in acting out their beliefs some women incurred the incredulous disgust of their friends.

Dancing was not the only activity which became a problem. Once they began to lose their sexual identity, the women found much more difficulty in knowing how to interpret men's overtures (37).

Early on, before they looked pregnant, interpretation was easy. They believed that men whistled at them because they still found them attractive, as Lynne said, "Before I really showed, you know, I was still getting the wolf-whistles. And I thought, 'Um, great,' you know. Can't look that bad after all!" But once they "showed" the girls thought that men could not be whistling in appreciation, as Elspeth explained: "A man generally whistles because he thinks somebody's NICE. And how could anyone think that somebody about 40 round the waist was nice?" Gina gave another reason: "Well, I dare say they're not really interested, because supposing I was SINGLE and pregnant, I mean, what man's going to come and take me out? Away out here. I mean, it's not even his baby."

They therefore tried to redefine the men's motives, but Gina for one found this difficult: "One night we were at the Queen's Hotel, and my husband and his friend went to the toilet, and his friend's wife and I were standing. And two guys - about twenty fourish, whistled. And I didna

know HOW to take it (giggles). I was puzzled - either they're BLIND, or they're taking the mickey, or something! I didn't know how to take it." There were various ways of "taking it" (or redefining it). Helen charitably decided, "obviously they don't know I'm pregnant," an interpretation which she based on an episode in a television programme she remembered: "It always stuck in my mind. It was a programme on the television, 'Not Infront of the Children,' and she was pregnant, and she's standing from the back view, and this chap whistled away, and she turned round, and her stomach's away out like that. And he just LOOKED at her, you know, as much as to say, 'I made a mistake there,' you know. I always think of it THAT way, from that thing that was on the television."

When some workmen whistled at Elspeth and two other maternity patients as they were struggling up the hill to the Ante-natal Clinic, she saw it as a joke and, because she was in a group, was able to laugh back. However, she felt that if she had been on her own she would have been embarrassed.

When Anna was waiting at a bus-stop and a stranger tried to get her into his car, she felt quite justified in defining him as a pervert: "He was a right creep. So he kept saying to me, 'Come on,' he says, 'Get in the car.' I says, 'You've got to be bloody joking,' I says, 'I'm standing here eight months pregnant.' He says, 'I like that sort of thing.' I says, 'Away, you pervert!' Like that, you know. I was really sickened by him." When she got on the bus, the driver was very concerned about her: "The Man says, 'Are you alright?' I says, 'Aye,' I says, 'Just that MAN,' I says, 'He's a bit of a pervert, he tried to get me in the car.' And even the bus-driver says, 'You're PREGNANT!' As if, how could he DARE, sort of style. I says, 'That's what I mean, mister.'" But when she told her husband about the incident he refused to believe her: "He says, 'You are definitely gone (i.e. definitely

pregnant).’ He says, ‘Who’d want to pick up you?’ I says, ‘I’m TELLING you!’ He says, ‘Was he good-looking?’ He says, ‘Who did he look like?’ Of course, I started pulling him all the jokes. I says, ‘Clint Eastwood!’ ‘Oh,’ he says, ‘You’re a blether. Nobody tried to pick you up!’”

Underlying this episode is the central assumption that Anna cannot be sexually attractive. That was why she defined the man as a pervert, why her husband disbelieved her and why the bus-driver reacted as he did. The driver clearly thought men should be protective and solicitous towards pregnant women and was shocked at the thought that any man might try to treat them as sexual objects. But significantly, Anna herself, although frightened at the time, was delighted by the incident, as her opening gratified exclamation showed: “Oh! I must tell you - somebody tried to pick me up when I was eight months pregnant!” She was gratified because vestiges of her sexual self remained, and the man’s interest was a re-affirmation of her desirability. She was really echoing Lynne’s, “I can’t look that bad after all!” Anna lied that her pursuer looked like Eastwood because Eastwood was accepted as a male sex symbol, and so if someone who was so attractive approached her, her kudos would be all the greater. If she had admitted that the man was unattractive much less status would have accrued, because it would have been easy to say that he only considered her because, owing to his own inferior looks, he was unable to approach a genuinely attractive woman. Deprived of her slim figure, a pregnant woman might be said to have fallen within his limited reach. But if a man who could take his pick of women desired her, it would show she was truly sexually attractive..

In summary, when the women thought they did not “show,” male attention pleased them. They interpreted it as a reassuring compliment. However, once they felt that they had lost their figures, they found themselves

unable to interpret the overtures in the same way, and so they fell to redefining their meaning. The various reinterpretations included persuading themselves that the men did not know that they were pregnant, or that they were joking, being cheeky or were perverted. But once pregnancy was over and the body had returned to its former shape, sexual overtures again appeared straightforward and were welcomed accordingly.

Misrepresenting Identity

Goffman (38) has suggested that "an audience is able to orient itself in a situation by accepting performed cues on faith, treating these signs as evidence of something greater than or different from the sign vehicles themselves." He points out that this tendency of the audience to accept signs places the performer in a position to be misunderstood. And, more pertinently here, this "sign-accepting tendency puts the audience in a position to be duped and misled, for there are few signs that cannot be used to attest to the presence of something that is not really there." Many performers have "ample capacity and motive to misrepresent the facts; only shame, guilt and fear prevent them from doing so."

Some women told me that they had had the opportunity to misrepresent their identity and pass as non-pregnant. Or more precisely, they passed themselves off as having a sexual identity when they regarded themselves as not having one. They enjoyed doing this because it was "a lark," a slightly daring, naughty thing to do, and because being treated as a sexually attractive woman confirmed that they were still attractive to men (see Judith's comment, "I felt sort of BOOSTED," in the following episode.)

When Judith was six months pregnant she gained much pleasure from misrepresenting herself to some men in a pub: "When I left my last job, they decided to have a night out. And it was just to go out for a drink.

Well, Alastair took me there, and he was going to pick me up, you know, after ten. And we went to the place, and two of the girls had arrived, and then I came in and I went and sat beside them. And we were just sitting chatting when all of a sudden these MEN came over. Well, they're old enough to be your father, you know, must be fifty if they were a day. And there were three; there were two who were about fifty odd, and then there was a younger chap who was about thirty odd. Then there was a really young one, maybe nineteen - not that I took much notice! (much laughter)."

Judith was keen to misrepresent her identity: "I had said that this was my ambition. I had said to Alastair, 'My ambition is to get chatted up when I'm pregnant and hide my stomach under the table,' so that when I stood up they'd go, 'Oh!' sort of thing."

She was able to misrepresent it because she was able to manipulate the one cue which was unmistakable proof that she was pregnant - her body. She managed this because she was sitting down, and wearing a long loose dress, "and anyway, I wasn't so big then." And so the men failed to pick up the most significant cue and acted on other, more ambiguous cues which were implicit in the situation (for instance, the setting of the pub, and the fact that Judith was not with a man.) Her youth, general attractive appearance and the fact that she was clearly dressed up for a night out probably also led the men to see her as a viable partner in a sexual encounter. Because they acted on these ambivalent cues, the men put themselves "in a position to be duped and misled," and left themselves open to ridicule, as Judith described: "Oh, and they were giving us all this junk, you know: 'Oh, how beautiful you look,' and 'I would like to paint you.'"

The men were perceptive enough to realize that the girls were married, but

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this only increased the confusion and hilarity: "And the girls were sitting nudging me and LAUGHING, you know. And they saw by our rings that we were married, you know. 'Oh, you're married! Have you any children?' And I said, 'Well, in a manner of speaking.' And we all sat giggling." It is quite possible for a performer to create intentionally almost any kind of false impression without actually telling a lie. Various communication techniques enable him to do this - innuendo, crucial omission and strategic ambiguity. Here Judith was using strategic ambiguity very effectively.

However, eventually one of the men picked up the all-important cue: "One of them who was married, he had NOTICED, you know, after they had sat down, he had noticed that I was in 'a certain condition'! And he was trying, he was saying, 'Can you no see the lady's pregnant?'" That is, he was trying to warn his friends to pick up the cue that the lady was 'out of play.' Like Anna, Judith found this episode very gratifying because it reaffirmed her latent sexual self: "But I was laughing, because I says, I'm DIEING for Alastair to come. I don't care, as far as he's concerned, there'll have been twenty of them, and as handsome as anything! You know, I felt sort of BOOSTED, that, oh well, I got chatted up and everything. I felt quite good." Her exaggeration of the men's physical charms was similar to Anna's claim that her pursuer looked like Clint Eastwood.

However, privately Judith felt obliged to undercut the episode in order to explain their behaviour. She did this by saying that the men were elderly ("old enough to be your father"), not particularly desirable, and were not altogether in control of themselves as they had been drinking. In this way she accounted for their "lapse" in approaching a pregnant woman. It is significant that Judith's married friends did not regard themselves as similarly 'out of play'. As Jean said, in a man's eyes a woman is

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" fair game " despite the fact that she is married or has children. It is only when she is pregnant that she slots temporarily out of play.

Self Imagery

In conclusion, an interesting way of looking at how the women saw themselves is to examine self imagery.

Women like Pat regarded themselves as decidedly abnormal because they believed that their shape was extremely odd. Most of the other girls also implicitly considered themselves to be abnormal when they spoke of " getting back to normal " or looking forward to " wearing normal clothes again " .

Several images expressed their feelings that they were conspicuous when they were pregnant. Those women who regretted losing their figures disliked feeling conspicuous because they felt it was based on their big stomachs, which they considered unattractive (see the Chapters on Body Image and Motherhood for an analysis of the relationship between self image, body image and reactions to motherhood). These images also had degrading or embarrassing overtones, and reflected a sense of vulnerability and helplessness. Occasionally they had an almost sub-human inference, (" You feel that BIG. And you see everybody else walking about in trousers and everything, and you're sticking out like a sore thumb !")

Christine used harsher imagery. Hers carried overtones of ugliness, helplessness, deformity and stigma : " Now I feel you walk down the street, and somebody maybe looks at your face, and then they look at your stomach " (bursts into laughter). You know, and you can see their eyes actually moving. The same on the buses and things, you know, people just stare at you. I don't think they do it - meaningly, you know. They just sort of - well, just like anything else, I mean, if you see somebody that's maybe a

cripple or something like that, you're drawn to THEM. You know, and you don't actually STARE at them, but you know - you can't help it."

Agnes' comments showed that even in her third pregnancy she, at least, still felt conscious of people staring at her. She told me that by the end of her pregnancies she always felt "out of the ordinary". She amplified this to say that she felt like "something out of the zoo" because people were staring at her and pitying her for being so big and tired.

Other writers (39) have described how some primitive peoples regard pregnant women as unclean and even dangerous. Joan's description of pregnant women had overtones of unsavouriness and impurity: "I think maybe people think that pregnant women are vulgar. You know, they sit there cracking dirty jokes with their legs apart and everything, and showing their knickers. Because Robert used to say that, he said 'You pregnant women are all vulgar.' Because they say dirty things without realising it, really. And also, you're going to the toilet a lot when you're pregnant, you know. Maybe that's what it is. You're always staggering off to the toilet. No wonder they think we're vulgar."

Her image of pregnant women smacked of "innocents abroad". Her mention of the toilet formed part of a series of references to excretion (40), which occurred sporadically throughout the whole process of pregnancy and birth. These came to a head during labour, when pushing pains were often described as a similar feeling to constipation. In fact, some women went so far as to be afraid lest they "did the toilet" whilst they were giving birth. Such images emphasised the elemental and socially disapproved ("nasty") aspects which the women felt were inherent in giving birth to a baby.

Similes were used to describe how unattractive the women felt. Towards

the middle of her pregnancy, Judith said she felt like " a real scrap-bag ", and after her delivery Pat described herself in the following graphic terms : " My ear was all sore, ken, with the starch off the pillows, and the side of my face and everything. And my eyes - what a laugh ! I was like a horror picture ! With pushing that hard I burst a blood vessel in my eye, and it was blood-shot. It was all red ... What a laugh - I was going about with one white eye and one red eye !" She therefore fell far short of the film-star ideal several women sought to achieve after birth. (The implications the film-star image bears for the women's concept of attractiveness will be discussed at the end of the following chapter.)

Sometimes the girls saw themselves in relationship to pensioners. Predictably, this happened particularly when they were travelling on buses and they found themselves in competition for a seat. On these occasions they were identifying themselves with a group in society which is publicly defined as needing protection and special treatment, and interestingly, they were unsure who should be given priority, themselves or the pensioners. Pat felt especially isolated and restricted during pregnancy. She regarded it as imprisonment, and her favourite self-image was of a bird in a cage. In sum, the imagery the women used about themselves reflected how conspicuous, unattractive and helpless many of them felt. It also reflected feelings of frustration and imprisonment at living such a restricted existence.

Conclusion

In this chapter I have discussed the women's identity. After a general discussion of self-image, the first part of the chapter examined the process by which the women came to see themselves as pregnant. This was not an easy process, both because it is such a major transition in women's lives, and because there are so few physical manifestations or societal procedures

to help them achieve the transformation. In the face of the absence of such procedures, they had to rely on their social group to remind them of their new identity, and on benchmarks they themselves constructed to supplement the meagre physical signs of pregnancy.

The second part of the chapter concentrated on an important aspect of self image, the women's sexuality. It showed how they felt themselves to be divested of their sexuality, and what effect this had upon their behaviour. The chapter ended with a brief glance at the imagery the women used to describe themselves.

Introduction

My women were preoccupied with their body image. The International Encyclopedia of the Social Sciences defines body image as a term relating to the individual's perception of his body (1). It encompasses his collective attitudes, feelings and fantasies about his body, and it represents the manner in which he has learned to organise and integrate his body experiences. Body image concepts are crucial for an understanding of such varied phenomena as adjustment to body disablement, maintenance of posture and spatial orientation and personality development. The pervasive significance of the body image is evident in the widespread preoccupation with myths and tales that concern body transformation (for example, in the works of writers such as Ovid, Shakespeare and, more recently, Kafka.)

Pregnancy is only one of the important transitional periods in individual development which involves body changes (2). Past researchers have noted that concern about body image is a central area of anxiety during pregnancy (3), (4) , but there seems to have been little systematic sociological study of this phenomenon. The study of body is also important in that, as my work will show, a woman's body image is closely related to what sort of a mother she will be.

The first part of this chapter discusses the range of meanings my respondents attributed to their body. The next section describes a number of case-studies which typify the variety of ways in which the women reacted to their changing body image, and goes on to discuss the ways in which they tried to come to terms with their new shape. The

chapter ends by drawing out the implications which these findings have for the women's general body images.

The relationship between a woman's body image and her attitude towards motherhood has already been examined (5). However, it tends to have been seen in rather static and simple terms ; this chapter will show that the relationship is more subtle and shifting than earlier writers have suggested. Pohlenius maintains that " the physiological raw material of the human body is of interest in so far as it is transformed by its social environment and ' embodied ' with social meaning " (6). Taking this as a starting point, the chapter begins by considering the range of meanings the women attributed to their bodies during pregnancy.

(1) Meanings of Body Image

(a) Establish self as pregnant

The stereotype of a pregnant woman is a woman with a huge stomach. Therefore it was understandable that some women wanted to gain weight and " show " in order to establish themselves in their new self. (The very term " show " suggests a visible sign and confirmation of the new identity.) " Showing " was seen as one of the few early signs of pregnancy (and the only obvious sign to others) and it was often welcomed as providing proof of pregnancy both to the women themselves and to others. (As Gina told me, " I've been dying for it to show just to prove it's there. ") Because she was still not showing after four months, Julie began to wonder if she really was pregnant : " I've begun to have doubts, you know. I really did, because, you know, I just don't show at all. I've only put on half a pound. "

Not only was showing construed as proof of the pregnancy, but some women expressed a feeling that it was unnatural not to show. Sheena said, " At first you're dying for you to show because you think, ' Oh heavens, I must be queer or something, I'm not showing.' " These women felt particularly abnormal in the presence of other pregnant women, as Kathleen explained, " Oh, the first couple of times I went to the Clinic I was looking all around me, you know, and I was thinking, ' They're all about seven months.' And I thought, ' I haven't even got a belly.' And whenever I go up, I never seem to see anybody small. I mean, I don't show very much for four and a half months. I hardly show at all. And, of course, I was always dying to get a bit bigger, you know. But I used to see these girls going up, and I thought, ' There's nobody. I'm the only one.' I thought, ' I wonder what's happened ? Have I stopped getting pregnant or something ? (giggles) ... You know, I feel terrible when I'm there, everybody's showing. "

Given this lack of obvious cues denoting pregnancy, " showing " became important as a way of establishing oneself in the new identity. Otherwise, despite the excitement of the announcement that a woman was expecting a baby, and the fact that she was sporadically acting as if she were pregnant (for example, by attending the Clinic), others might still wonder if she really was pregnant. Pamela was particularly irritated that her body image had not caught up with her identity : " Nobody can see I'm showing. The other day, I think it was Saturday night in the shop, one of the local ladies that comes in, I says, ' Do you no think I'm getting fat ?' She says, ' Aye ', she says, ' How many weeks are you ?' I says, ' WEEKS ? I'm nearly five months.' She says, ' ARE you ? ', she says, ' You dinna look it.' Everybody that I tell that I'm pregnant all

say, ' Och,you're not PREGNANT. You dinna even look it. Three weeks, aye,but no five month.' " She explained that she was keen to " show " because," if folk say to you,you know,folk that KNOW that I'm pregnant, they just sort of look at me, and say, ' You're no showing yet. '

Well, I get the impression, I'm stupid, I know, but I get the impression they think maybe she's no pregnant. She's kidding us on, or something " (7). Some women wanted to put on weight not merely to " show ", but in order to advertise the fact that they were pregnant. To them, their bodies became an expression of their pride, a symbol of their happiness at being pregnant, which they were keen to " show off ". As Goffman (8) has said, the body is a sign which conveys social information. When the person is proud of the self, the body becomes a status symbol.

Elspeth saw it this way : " Well, I knew I was pregnant, and I suppose I just wanted everybody to know. Everybody else to know I was happy." Instead of emphasising her personal feelings of pride, Joan stressed the universal importance of pregnancy. Telling me why she wanted to " show " , she said, " Well, I like seeing pregnant women walking about. I think it's an IMPORTANT thing,people being pregnant. And it doesn't really show enough. Women always hide it in big coats and things. (giggles) I don't think they're appreciated enough. I mean, people should be, I don't know, get a thrill or something when they see a pregnant woman - I think. Instead of thinking, ' Oh, there's another population explosion. ' I see it as something really wonderful, but I don't think people seeing a pregnant woman think that at all. They just sort of move over a bit, make room for them. " Joan attached this high value to pregnancy because she saw it in terms of creativity,

and she attributed this to her Catholic upbringing.

These women were proud of being pregnant because they saw it as an achievement. Most of them had always wanted to be mothers, and they assumed that everyone else shared their high evaluation of pregnancy and motherhood. However, these positive feelings towards their new body image were sometimes modified, as the second part of this chapter shows.

(b) Proof of Parenthood

Maggie was glad she "showed" as, to her, her body offered proof to others of her parenthood. She said, "I mean, if you weren't SHOWING, and you just sort of went through your pregnancy without, then people'd be saying, 'Whose is that baby in that pram?' You know, 'It's mine, I had it last week.' That's what my cousin, you know, she was due a couple of weeks ago, and she said to me, 'You know, when I had Ian, I didna even show at all.' She says, 'I had been up to the Clinic and I got taken in,' she says - this was in South Africa - 'I got out on the Tuesday,' she says, 'And the next again week I met this girl.' And the girl says to her, 'Who's is that baby?' She says, 'It's mine.' 'But', she says, 'You've never been pregnant.' She says, 'That baby's only a couple of weeks old.' She says, 'I know,' She says, 'But you werena pregnant.' She says, 'I was so! I just got out of the hospital last Tuesday.' And I says, 'Oh, well.' She says, 'I wasna even showing that I was pregnant.' Well, she IS pretty stout, you know, all over. She always has been fat. And she says, 'I wasna even showing that I was pregnant. People wondered where the

baby had come from. ' "

Maggie thought that her cousin had been in an unenviable position :

" I don't think it would be very nice, people not knowing that you were pregnant ; and sort of looking at the baby and saying, ' I wonder where she got that ? ' You know, they might think you'd adopted it, or - it's not your own. " Her comments suggest that she felt that rearing a child of her own flesh and blood was preferable to rearing someone else's, and the only conclusive proof that the child was her own was afforded by her body.

(c) " It's something different "

Some women enjoyed " having their bump " because it was so different from their usual appearance. There were several interpretations of the way in which it was " different " .

For Julie, her " bump " represented her baby : " I shall be sorry when it's gone, really. Especially when I'm sitting here in the afternoon by myself, and it'll be kicking away, you know, and I think I'm not all by myself, not REALLY. Because you can feel the baby kicking away, you know ... I want me baby AND me bump, you know. Because I like my little bump, I like the way it kicks about and jumps up and down ! (laughs) You know, it's something different ,any way. "

Joan looked forward to experiencing what it was like to be a different shape. At the beginning of her pregnancy she told me, " I'd like to get really big. Just to be - completely different from normal. And then go back to normal. I've always been quite thin, really. In the arms and that, anyway. So I don't mind getting big at all. I like it to

show. And then it can go away again. "

(d) Sign of Privileged Person Status

Initially Joan also saw her body as a sign to others to treat her in a solicitous way. She told me that she wanted to get really fat so that she would get " privileges " (for example, people would give her seats on buses.) However, her expectations were misplaced. It was interesting that she then redefined her attitude and claimed that she would be embarrassed if anyone tried to treat her in this " special " way. This may have been a coping mechanism for her disappointment, and it may also have reflected the fact that originally Joan was keen to establish herself as being pregnant (because it was a new experience and a wonderful state), but on examination her feelings seemed rather ambivalent. Throughout her pregnancy she tried in various ways to assert her " normal " self at the expense of her pregnant identity. She had not planned to become pregnant, and after the birth she told me that she had not enjoyed the experience. Therefore her reasoning that pregnancy would offer her a new experience and special treatment may well have been a mechanism by which Joan coped with her dislike of being pregnant, and her eventual embarrassment at being treated as pregnant may have resulted from her desire to be seen as " normal ".

In all her interpretations Joan did not refer to her body as a sign of the baby and her impending motherhood ; instead she saw it solely in terms of the present and herself.

(e) Benchmark

As the last chapter showed, some women did perceive their body in terms

of baby and motherhood. For example, Gina and her husband welcomed her changing shape as a cue that she was nearing term : " My husband gets quite delighted if he sees I'm that bit fatter, because he feels you get so fat, and then, after that, you're drawing near the end - the count-down as he calls it. "

(f) Check Against Activity

To some, their bodies became a useful check against indulging in strenuous activity which might endanger the baby. Elspeth explained, " Well, at first, I suppose, you've got to take it easy, because you don't know there's anything different about you. But once you've got that bump, you CAN'T do the things that you shouldn't do anyway. "

(g) Body Image as Embarrassment

Sometimes the women were embarrassed by their bodies. Maggie told me, " The other night I was sitting, and my sister was in with her friend and their two boyfriends. And I felt my arm going like that (twitching) because it was moving, you know. I think it must have been kicking. And my arm was sort of moving up with it. I thought, ' Oh, goodness. ' Because it was the first time I'd met their boy friends, and I felt sort of conspicuous with my arm moving up like that. ' They'll think I'm a bit daft. '"

(h) Threat to Attractive Self

We saw in the preceding chapter that several women believed that a pregnant body spelt the loss of their sexual identity. (For a detailed discussion of this meaning see the case study of Sophie in the following

section.)

(2) Reactions to Body Image

Introduction

If we follow Sherif's argument, we could say that during pregnancy a woman belongs to different groups whose values conflict (9). She has as one reference group her non-pregnant, sexually attractive friends ; she has as another those women who are mothers or expectant mothers. She is therefore faced with a choice in abiding by the values of one reference group at the expense of the other.

There seems to be a continuum of reactions to pregnancy. At one end there are the strongly 'maternal' women who emphasize their new role of motherhood and are proud of their body during pregnancy (exemplified here by girls like Ruth, Alison and Julie). At the other end are those women who stress their identity as sexually attractive women, wives and perhaps workers, and who dislike their appearance during pregnancy (illustrated particularly by Sophie, Jean and Pat). To some extent these clusters are mutually antagonistic. In this way, a woman's reaction to her body image can reveal a lot about her attitude towards motherhood. This argument is further amplified in Chapter Eleven.

It is important, however, not to be too simplistic. For example, in any discussion of body image it is essential to know what meaning the women give their bodies, for, as we have just seen, body image can mean several things besides the loss of sexual identity. And, as we shall see in the following section, women sometimes redefine their body image during pregnancy. At some stage there is generally a crisis of identity when

the woman is faced with assuming the new role of mother and divesting herself of her sexual self. However, this transformation is rarely fully complete. Vestiges of the former sexual self tend to remain and find expression even at the end of the pregnancy when the women have most firmly renounced their sexuality. This can be seen most clearly in the discussion which follows of Anna's shifting reactions to her body image. The women reacted in a variety of ways to their changing body images. Ruth and Sophie represented the extreme ends of the continuum. No other women consistently adopted such extreme positions. Their case studies are useful in showing the limits of the continuum. Ruth and Sophie maintained a consistent attitude towards their body throughout the period, but it was more common for attitudes to change as pregnancy progressed. This might involve the women in redefining the meaning of their body image. There seemed to be no systematic socio-economic variation in the pattern of reactions.

Where relevant, I have included the women's definition of jokes and jokers, as these can often provide useful insights into their body images. Several women told me that people joked about their appearance. The jokes varied from simple names like "Fatso, Tubby and Slim" to more elaborate images. For example, Julie was told that in her black coat she looked like a skittle, and at Easter time Maggie's friend offered to take her up the local hill and roll her down. People also made exaggerated comments about the effect of the women's weight; several were teased about their supposed inability to get through doors, and when Julie went to sit down on a bench, the other occupants immediately jumped up, ostensibly in case she tipped it up, crying, "Mind, Julie's going to sit down!"

Perhaps people joked because, as Boston says, " Men, like gods, laugh at deformity and humiliation " (10). Perhaps their laughter also reflects their uncertainty or embarrassment as to how they should behave towards a pregnant woman. Freud has suggested that humour is aggressive , that it comes from a feeling of superiority to the object of the laughter, and is a socially permissible means of release from tensions and inhibitions (11). Humour gratifies hidden and inhibited wishes, and simultaneously discharges anxieties in a harmless form. Because most tensions centre on sex, excretion or aggression, these are the main themes of humour. And Goffman has pointed out that it is natural to find joking and embarrassment together for both help in denying the same reality (12).

(a) Total Acceptance Throughout : Ruth

Ruth was at the extreme positive end of the continuum. No other woman maintained such a consistently positive attitude towards her appearance. Ruth had always wanted to have the " joy of being a mother ", and immediately upon marrying at the age of thirty she and her husband set out to have a baby. Pride characterized her attitude towards her appearance. She saw her body as a sign of her baby and her motherhood, and her pride in her body made it impossible for her to feel any embarrassment at " showing ". In answer to my question as to whether she was concerned about losing her figure, she replied, " No, actually, I think I'm too PROUD of the fact that I'm going to have a baby. I mean, I think I walk down the street, and I don't care how big I am. I think I'm so proud of the fact that I'm pregnant that I just want everybody to SEE it. You know, saying, ' This is me, and I'm going to have a baby, and I'm PROUD of the fact. ' No, I don't mind. I'm 40 round the bust !

And I'm WELL over 40 round the hips ! But no, it doesn't bother me. " Ruth defined the whole process of pregnancy as normal. This definition had important implications in that once something is designated as normal it immediately becomes less of a problem and easier to handle. Therefore, it was in keeping with her overall attitude to pregnancy that she could categorise gaining weight as natural : " Some people say to me, ' Oh, look at the size of you ! ' I says, ' Well, it's all mine. ' No, I don't feel embarrassed, because, to me, it's nature again. It's a natural thing. I think it's something to be proud of. I don't think there's anything to be ashamed of, that you're going to pull your coat over it and hide it. I don't feel that way about it. I mean, why should you ? "

Ruth and Pat represented opposite ends of the continuum in this. To Ruth, gaining weight was an inevitable and necessary part of becoming a mother, but Pat's attitude was very different. Pat felt that her appearance was distinctly abnormal because it was out of proportion. But her definition of normality was based on the shape of non-pregnant women, whereas Ruth's definition was grounded in her perception of pregnancy as a precursor to motherhood. Their two reference groups were entirely different.

Virtually all the women were very keen to regain their figures, and planned to diet and exercise rigorously after the birth. But Ruth was not overly concerned about this. In this she was very unusual. She acknowledged the fact that she might not regain her figure, but she knew that she would be unable to diet because she wanted to breast feed her baby. Breast feeding, and enjoying the special relationship with her baby that she believed it allowed, was far more important to her than

regaining her figure. She had a rather fatalistic attitude towards her weight : " I mean, some people DO tend to put on weight. Whereas some people seem to lose it a lot -- it's probably just the way you're born. I mean, there again, you're just going to have to wait and see what happens. " Earlier she had explained that it was "hard" for her not to put on too much weight : " I don't eat an awful lot of what I shouldn't, you know, sweet stuff and that. But I just seem to have naturally gained quite a bit of weight. So - it's just one of those things that happens ! " She accounted for the differences in size between women by believing that size was a reflection of how a woman carried her baby and that every woman carries it differently. These arguments, which emphasized her lack of control over her appearance, contrasted markedly with Sophie's belief that she could exercise a great deal of control over her body during this period.

Although Ruth did little to lose weight, by eight weeks post partum she felt that her figure was roughly what it was before she became pregnant. She was unconcerned about regaining her figure, telling me, " but I didn't mind being pregnant either ... I didn't mind having my bump at all. " The only advantage she could see was that she again had a variety of clothes to wear. In some ways she even missed her 'bump' ; it provided her with " a wee ledge " upon which she could rest her cup when she was drinking tea ; and when the weather was cold, it provided her with heat. From these comments it seemed that her 'bump' had become a part of her in a way that did not happen with the wife/worker women like Sophie or Pat. Ruth's reaction here was typical of the more ' maternal' women . I felt that her reaction to being overdue was also significant. Most women told me how much they feared the prospect of being overdue,

because they felt so ugly and awkward by the end of their time. But Ruth alone remained unconcerned about her size (despite the fact that she " got really enormous coming to the end " and " began to get terribly awkward ") until acquaintances repeatedly reminded her that she should be in hospital. She said, " Well, the only thing that annoys me really when you go over - I mean, I myself wasn't concerned because I was overdue - but you go down to the shops and people say, ' Are you still here ? Are you not going to drop that ? ' You get to the stage where you feel really like screaming and saying, ' Oh, give me peace ! ' I used to say, ' Och, he's keeping me warm, leave me alone. ' As I say, I never really felt that he WAS overdue until people started saying, ' Are you STILL hanging on ? ' And then you begin to say to yourself, ' Oh, AM I a long time ? ' "

Ruth was also unusual in that she expected to "bloom" during pregnancy as a result of the pride she was feeling : " I thought to myself I should really be looking WELL. Because, I mean, you FEEL you should be feeling so well. I mean, it MUST show in your face. And the pride of it all. It's BOUND to show in your face. " Ruth therefore saw pregnancy as a time of heightened health and beauty and, unlike the wife/worker women, recognized another way of being attractive as well as the sexually attractive image based on the slim figure. However, Ruth did not believe that " the bigger, the better ". Instead, she believed that there was an ideal size, and that to exceed it would cause embarrassment. For instance, when I first met her, she felt embarrassed at wearing smocks at two and a half months, and later she was acutely conscious that her breast measurement was now 42 inches (" It seemed a drastic change from 36 when I first started out ! ") She seemed to form her ideas of what

was acceptable by comparing herself with other pregnant women (usually her sisters), and by accepting the opinion of the medical staff that a low weight gain was desirable. She was also able to use several coping mechanisms to assuage her embarrassment. Her fatalistic attitude was instrumental here, and she was able to combine this with her belief that "everybody's different." And, as regards her breasts, she soon persuaded herself that "with my bump, you don't notice it as much." The husband's attitude towards his wife's body often helped determine her reaction to it. Bill's attitude was certainly crucial in helping Ruth maintain her pride in her body. She told me he loved children and had always wanted to be a father, and so was delighted at the prospect of having his own child. The baby seemed much more central to their marital relationship than Ruth's physical appearance (in contrast to less 'maternal' women.) When Ruth wondered if he might be embarrassed at taking her to a dance when she was nine months pregnant, he told her, "No, don't be daft. It was me who put you like that." He says, "I'm proud of you like that." Most women tolerated jokes against themselves, probably because they felt that they ought to be able to 'take a joke.' Perhaps because of her proud and joyful acceptance of her appearance, Ruth was particularly tolerant of jokers and their jokes. She saw joking as a natural reaction ("Well, you expect people to say SOMETHING about you getting fat!") She gave the following reasons for her tolerance: "I don't feel as if anybody's saying to me, 'Hello, Fatty,' that they're being nasty. I don't think that anybody would probably genuinely hurt your feelings. I think they probably just say it as a joke if they do say anything. Oh, no, I don't imagine that anybody would hurt your feelings when you're like this,

because I mean, after all, they've probably been maybe in the same position themselves, some of them. She added that, "It doesn't annoy me in any way that somebody would say to me, 'Oh, you're terribly big.' I mean, I'm proud of it, so why should you get embarrassed?" In this way Ruth tended to see pregnant women almost as a protected group, and from her position of confidence she was able to accept remarks and answer them with spirit.

In sum, Ruth welcomed and readily accepted the new role of mother, and this was reflected in her attitude towards her body. However, vestiges of her sexually attractive self remained; for example, she told me she would be pleased to be able to wear a variety of clothes again, and almost as an after-thought, she added, "You probably feel good if you can slip back into something you wore before. You know, you'll probably feel you've got your figure back again too."

(b) Rejection throughout: Sophie

Sophie represented the opposite end of the continuum from Ruth.

Together with Pat and Jean, because her only definition of an attractive body seemed to be the slim one, she necessarily found the pregnant body ugly, and she assumed that everybody else shared her belief. She told me, "O.K., some people say that to them a pregnant woman is a lovely sight - blooming with motherhood and all the rest of it - but to me, figure-wise, -there's nothing nicer than a nice, slim, trim, figure, flat tummy, and you can wear all these nice trendy clothes. And, to me, the nine months and the bit afterwards, when you're still a bit sort of flabby, to me it's not particularly pleasant to look at I don't think it's a particularly appealing shape. I like a nice, trim figure,

and I'm looking forward to getting my nice, trim figure back. " This belief was the basis of her reaction to her body, and explained why she went to such lengths to hide her shape. It also explained why, in Goffman's words, "the tales of (her) fellow-sufferers bore (her), and that the whole matter of focusing on atrocity tales, or group superiority or trickster stories, in short, on the "problem" is one of the penalties of having one" (13). For example, Sophie tried to refrain from entering into conversation with other patients at the Clinic because she believed that she was "pregnant twenty four hours of the day" and she preferred to "forget about it sometimes." Throughout her discussion of her body image Sophie, unlike Ruth and the 'maternal' women, stressed self-determination and self-control.

Like many others, Sophie had been uncertain how she would look when she was pregnant. She had feared that she would resemble her sister: "The only person I've ever been CLOSE to who's been pregnant is my sister. She always had a tendency towards plumpness, and she always LOOKED pregnant from about two months onward - you know, sort of STOMACH and the BOSOM and all the rest of it. And I used to think, 'Ugh!' you know. Really - I wouldn't like to be like that." Instead, Sophie's aim was to retain her figure for as long as possible: "Of course, obviously it varies from individual to individual. And you used to hear about other people saying, 'Oh, so-and-so didn't look pregnant at all until she was seven months,' or whatever. And I used to think, oh, that would be really nice - to get to four or five months without looking too OBVIOUSLY pregnant. Well, I'd be quite pleased." Her reluctance to relinquish her sexually attractive self and take on her pregnant identity was evident

in the way that she equated "looking pregnant" with "losing interest in yourself." She was dismissive of women who emphasised their pregnant appearance and thereby, in her terms, lost their sexual identity: "They tend to lose interest in themselves, and their main idea from the moment they find out they're pregnant is to LOOK pregnant. So they start wearing smocks and sort of pushing their stomachs out and taking it easy."

She believed that, at least in the early stages, a woman could have either one identity or the other, and she chose to maintain her sexually attractive self as long as possible. She also felt that it was imperative not to use the baby as an excuse for "letting herself go" after the birth: "A lot of women seem to think that it's the accepted thing that you don't HAVE a figure when you're pregnant, and you put weight on afterwards. Your waist tends to thicken and you've got a big bottom and all the rest of it. They say, 'Hell, I've had a baby,' you know. 'What more do you expect?' So they use that as an excuse to perhaps let their figures go, and think, 'Well, people'll understand, you know, I've got a baby here. You can't have a baby and still stay slim.' But if you look at it sensibly, there's no reason why you shouldn't, you know, get back to the same figure that you had before. And there's no reason why you SHOULD sort of try to be a frousy and lumpy fat housewife, you know. Dreadful thought!" By "looking at it sensibly" Sophie meant exerting control and not over-eating, slouching or allowing her stomach muscles to go slack. Emphasizing the individual's autonomy, she added, "It just depends on yourself."

Sophie coped with her new appearance by dressing to camouflage her

shape. This was a common coping mechanism. Whenever I saw her it was obvious that she had spent a lot of time on her appearance: she was always brightly and fashionably dressed and wearing make-up and an abundance of jewellery. By dressing in this way she successfully diverted attention from her stomach to the rest of her body. She also lulled herself into believing that her "bump" was not there - so much so that when she glimpsed her naked body in the mirror, it came as a "depressing shock ." (This was almost suggestive of the "self-hate and self-derogation" which Goffman claims a cripple can feel "when only he and a mirror are about" (14)).

Sophie was one of the few women who detested hearing remarks about her shape. She said, "I mean, I'd rather people just kept quiet about it. I mean, I KNOW I've still got this big bump in front, and I'm 34 round the waist or whatever, but I don't like people bringing it to my attention all the time." She felt that comments about her size were irrelevant and obvious. She believed people made them because they thought it was expected of them, or because they were "trying to be funny" (but she felt "if you've heard it once, you've heard it a hundred times"). Sophie thought that women were often being deliberately malicious in their remarks: "I always get the impression that women are being a wee bit snidey about it. Saying, 'Hee, hee, I've still got my nice, slim figure and you've NOT,' type of thing." She believed that women referred to her weight because it made them feel superior : "I think some of them too - I don't know if it gives them a feeling of superiority or whatever, bringing something like this to your attention when you already KNOW. You KNOW you've put on a stone and a half in weight, so why on

earth do they insist on reminding you about it all the time? ... There's just something there. A sort of little wicked streak in everybody; as I say, you know, if you've got spots, 'Oh, you've got a spot on your face!' (excited tones) To me, they're just being cruel. They're bringing it to your attention. And you'd probably rather forget about it. YOU know damn fine you've got a spot on your face, so why don't they shut up about it?" (angrily).

However, she went on to turn this argument round, and claim that other women were basically envious of the fact that she was pregnant. (This was an unusual response.) Sophie explained, "Although probably deep down they were really ENVIOUS, you know. Probably just wishing that THEY were having babies." Given that she believed that every one shared her preference for a slim figure, it was logical for her to see women who passed comment as malicious. She coped with what she perceived as their nastiness by falling back on the common stereotype of women as always wanting children. By attributing their "snide" remarks to envy, she reinstated herself in the superior position. Implicit here is her belief that pregnant women are a group who are particularly vulnerable to criticism about their looks - in short, who are potentially stigmatized. As she gained more weight, Sophie's appearance necessarily deviated more and more from her ideal. It was therefore imperative that she should develop mechanisms to cope with her body image. We have already seen how she dressed to hide her "bump" and how she quashed jokes, but she also relied upon certain reassuring beliefs about her body. For example, she reminded herself

that she was only losing her figure "on a temporary basis," and persuaded herself that she would regain it after the birth because, through controlling her diet, she had only gained the desired amount of weight. She drew a sharp distinction between being fat and being pregnant: "When you're carrying a baby, it's not YOU that's fat. You're carrying a CHILD inside you, so therefore you've GOT to make allowances for the difference in shape." All these were fairly common ways of coping. And like most of the other women, she presented herself relatively, and tried to convince herself and others that she was "not as bad as some that I've seen at the Clinic."

She also drew support from her husband. But instead of assuring her that he was proud of her for being pregnant, as Bill assured Ruth, Charles reassured Sophie that she "didn't look too bad" : "The only thing he's ever said is purely objective, 'Oh, you're getting that bit bigger now.' You know, with the baby. And, you know, reassuring remarks like, 'You're not as bad as some that I've seen. You're really quite neat.'" Thus both husbands seemed to share (and shape? (15)) their wives' attitude towards pregnancy and their appearance, and were therefore able to offer reassurances which their wives could accept as valid.

Perhaps one of the most interesting things about Sophie was that she alone managed to maintain her sexual identity. To be seen as a sexual being was certainly very important to her - but then it was to some of the other women too, but they eventually relinquished their sexuality. Berger claims that " We live our everyday lives within a complex web of recognitions and non-recognitions. That is, we become

what others expect us to be" (16). Following on from this, perhaps one of the significant factors in Sophie's case was the way her male friends reacted to her new appearance. She told me that she had expected to lose her sexual appeal, and that men would begin to treat her as a non-sexual being. However, when she found that they continued to greet her, "Hello, sexy!" she decided that she might be able to retain her sexuality after all. As I described in the previous chapter, other women in the sample redefined male attention. Perhaps Sophie did not feel obliged to do this because she could believe compliments from men she knew at work, whereas women like Elspeth and Gina could not so readily believe strangers in the street (17). Berger has shown that every identity needs specific social affiliations for its survival (18), but some of the women lacked Sophie's male work mates to reinforce their sexual self image. The timing was important too. Sophie was being fed this image of herself before she left work at six months. This was at a time when she was still not very "fat," which made it easier for her to accept a sexual self image. Once she had found that she could still be "sexy" even when she was pregnant, she was able to maintain this identity throughout the rest of her pregnancy. Ruth's and Sophie's attitudes to pregnancy and motherhood are further explored in Chapter Eleven.

(c) Redefinition of body image

Most women redefined their body image at some stage during their pregnancy. This was the most common pattern: the women felt an initial desire to "show" because they felt proud and happy to be pregnant, and wanted to establish themselves in their new identity. But towards the end of

their pregnancy they began to long to be rid of their "bump." This was partly because they no longer needed to work to establish themselves as pregnant; and partly because the novelty of their new appearance had worn off. Moreover, by this time they were often beginning to notice disadvantages in their size. They grew weary of the physical restrictions their bodies imposed (for example, Sheena had to ask her husband's help every time she wanted to get out of the bath). And being pregnant sometimes impinged on their social life; it meant they were unable to drink or dance as freely as before, and the previous chapter described how their body image left them less eager to go out in company. This redefinition of their body image also involved a redefinition of the meaning they gave to their body. From seeing it as proof of pregnancy the girls came eventually to see it as the antithesis of the sexually attractive and comfortable self. There were variations on this common pattern: -

Anna and Jean

When I first saw them, both Anna and Jean were eager to keep their figures and both were alarmed at the prospect of "getting fat." However, by the end of their pregnancies their attitudes had changed. Jean effected this change by resorting to self-persuasion, whilst Anna fell to reinterpreting the past (19). After her delivery when further self-persuasion was unnecessary, Jean's image of her body predictably changed again:

At the beginning of her pregnancy Anna emphasized, "I just hope I dinna get too fat. I'd be TERRIFIED incase I got fat after I had the baby. I would never like to get fat. When I got married I was seven stone. And I was 32:22:33... and I think, oh, I'd LOVE to be that way again! I think

if I was still nine and a half stone after I had the baby, I would die."

Her preference for the slim, attractive figure was reflected in the fact that in the early months of her pregnancy she wore a girdle at a relative's wedding in order to look "as flat as a board."

By the time she was eight months pregnant, it was impossible to hide her stomach, and her body image changed accordingly. Anna had internalized the maternal role much more by then, and, as part of this process, had reinterpreted her past feelings so that they appeared consistent with her present stance. At eight months, therefore, she said that she had always wanted a big stomach and assumed that all women shared her feelings: "I think everybody does. I mean, dinna believe half these women that say, 'Oh, I want a baby, but I dinna want to lose my figure,' sort of style. You do want to lose your figure. But you want it back again, right enough. But you do want to show off a wee bit. I know I did, and I'm not ashamed to admit it. And I used to get quite hurt when folks didna realize I was pregnant, you know, and I'm trying to go, 'Um, um, um!'" (pushing stomach out).

Probably what happened was that throughout her pregnancy the two selves, the slim, attractive self and the pregnant/maternal self, juggled for ascendancy. At first, the slim self was in the ascendancy, whilst the maternal self asserted itself intermittently, depending upon the nature of the situation and the people present. But by eight months the maternal self was in the ascendancy, and this was reflected in the fact that Anna reinterpreted the past in such a way that the maternal self seemed always to have been the most pervasive. However, vestiges of her sexually attractive self remained, and these left her ambivalent about her appear-

-ance. She said, "All women, when they're pregnant, I mean, they're quite fat. There's nobody you could actually say is elegant when they're pregnant. I dinna think so, anyway. I mean, you can be dressed in a twenty pound dress, hair done, but you still wouldna feel elegant. Maybe you would look nice, but you wouldna feel elegant."

Her sexual self also found expression in her desire for "sexy nighties" to wear during her stay in hospital. All the women told me they were taking new nightdresses into hospital. No doubt one reason was that they wanted to create a good impression and appear respectable, but perhaps another was that those days in hospital were the first time since the beginning of their pregnancy that the women felt able to regain their sexual identity. They usually expressed this by saying that having new and pretty night clothes "boosts my ego" (i.e. sexual self), and by using the image of the film star.

For women like Anna and Jean, who wanted to look sexually attractive, the film star image expressed exactly the look they were trying to achieve. Jean admiringly described how her sister managed this after her third baby was born: "But as soon as she went into the Victoria, one of the women says to her, she says, 'I feel terrible looking at you. You're sitting there like a film star,' she says, 'And I feel kind of ---' This was her first, and she had felt terrible; and this was Deidre's third, and not long after she had it. She was up, and you ken they let you have a bath and everything? Well, she was all washed, and she's got blond short hair, all sort of wavy, and she had her rollers in, and she had all her make-up on, and she had a pink, see-through nightie, and she was sitting up in bed all dressed up like a film star, and all the women were looking at her and saying, 'Oh, she looks nice' (wistfully). She's

really good."

"Sexy nighties" played a central part in Anna's plans to achieve the film star look: "I've bought nightdresses, like. Just two new ones, and two that I've no worn very much. Sexy ones, you see, that I couldna wear when I was pregnant!" She described with some amazement but much amusement how her sister had carried this look to extremes: "My sister - you want to see the nightdress SHE went and bought. Like I told you, she's extravagant She went and bought an eight guinea nightdress - long, white, SEE-THROUGH, lace, plunge neck-line down to there, and it's all lace. And then it's like a Grecian style, you know? And no back in it. And she was sitting up in bed with that on. After she had the baby. 'Course, she'd got a 'bra on, right enough. And my husband and me went in to see her with my wee sister. And she's sitting there - oh, absolutely STUNNING! And Paul's eyes were popping. My wee sister says, 'Oh, Jane, put on your bed-jacket. You look just like Raquel Welch sitting there.' And Paul says, 'There's no point now, I've seen it all.' But Jane just says, 'Why shouldn't I look feminine if I want to?'"

As far as Jean was concerned, it was not a case of different identities struggling for ascendancy. For her the slim, sexually attractive self was always in ascendancy, but as she got bigger, when she felt she had no hope of maintaining her sexual identity, she felt obliged to resign herself to her shape.. She did this by persuading herself and others that she was quite content with her appearance. (As she put it when she was eight months pregnant, "I bothered THEN" - i.e. at six months - "But no NOW. You just have to get used to it.") Again her husband played a crucial part in helping her perceive her body in a more positive way. He redefined her "bump" as "cute" and reassured her that when he looked at

her he did not see the fat, but the baby, which he loved. These reassurances helped her cope with the fear that her husband might dislike her because she was fat (20).

After the birth Jean was able to admit that she had hated being pregnant.

She explained how she felt during her pregnancy : " I felt old when I was pregnant, because I was carrying all that weight around with me. And I felt oh, blinking sick ... Here I am, stuck with a big, fat horrible - and I kept thinking he'd go out looking at other women and all the rest of it. And I was right jealous . And I was aye fighting with him ... I HATED being pregnant ; it's HORRIBLE. I didna even want him to LOOK at other lasses, because I felt oh, he's looking at them, thinking they're nice, and then he'll come home and look at me and say, ' Oh, I wished I never got married. ' THAT'S what it was."

Her comments underline the importance Jean attached to a sexually attractive appearance in marriage (21), and expose her attempts at self-persuasion as a way of coping with her body image. Pamela was the only other woman who expressed similar feelings. Their reaction contrasted markedly with that of the women of 'Ashton' (22), where it was considered suspicious if women continued to look attractive after marriage. It also contrasted with Gorer's findings that English husbands were more concerned that their wives should be good housekeepers than that they should be good-looking (23).

Anna and Jean also coped by promising themselves that they would work hard to regain their figures after the birth. This was a common coping mechanism. It helped them endure their weight during pregnancy, but exacerbated their depression after the birth when they found themselves

slow to lose their excess weight. Anna described the following incident which occurred in the hospital after she had given birth to Charmaine :

" You should have seen the state I was in. Two or three days later you get weighed. Well, I was ten and a half stones when I was pregnant at the end , and Charmaine was six pounds, fourteen and a half ounces. So this staff nurse, like, she was sort of cheeky, but she was funny with it, ken. I mean, I was AYE back-chatting her. She said I was ten stones. I says, ' I can't possibly be ten stones, staff nurse. ' She says, ' Why not, Mrs. Hart ?' I says, ' Well, the BABY was half a stone ', I says, ' What about all my water ?' I says, ' Look at me ! ' I says, ' I'm no ten stones. ' She says, ' If I say you're ten stones, you're ten stones. ' I says, ' Look, I'll take my dressing-gown off, ' and she wouldna let me. I says, ' That must be a few pounds. ' She says, ' No ', she says, ' You're ten stones. That's what I'm putting down on your sheet. ' I says, ' Well, if I'm ten stones, you must be fifteen stones ! ' And she just looked at me, you know. I says, ' Well ! ' "

The following night Anna discovered that the nurse had been teasing her, and that her real weight was nine stones, but by that time she had had time to become depressed : " And she really DEPRESSED me. I was walking along the ward and I was nearly GREETING. There was tears in my eyes. ' Ten stones ! ' I was saying to myself. ' Do I look it ? ' I was looking forward to feeling skinny again. "

Both girls agreed with Sophie that a woman should not relinquish her attractive identity after having a baby, But Jean found this aim difficult to achieve. She found that early motherhood marked another stage transition in her body image : " I've really let myself go ... Like, I

canna get my clothes on. My dresses and everything are still far too tight. My waist's still 28. I canna get my trousers on. And I get that I canna be bothered getting dressed or anything ... I'm still nine stones. Well, see, I never have TIME to do anything with myself. I mean, I can't just say I'll go to the hairdresser's, because I canna, because I've nobody to watch her. And I canna do my hair myself ; I've never been able to. And you've no got time to put on make-up during the day because you're running up and down, and you're doing this and you're doing that ... and it gets tiring."

In conclusion, Anna and Jean showed a shift in attitude towards their bodies during their pregnancies, and this shift reflected whichever self - the sexually attractive self or the maternal self - was in ascendancy. Each used a different technique to achieve this shift (Anna used re-interpretation, whilst Jean relied upon self-persuasion) and to convince themselves that they were content with their appearance. Post-partum, their high evaluation of the attractive self emerged in their dissatisfaction at " letting themselves go ". The importance of " not letting oneself go " will be discussed more fully in the next section.

Bloss (24), an American doctor, reported that probably the most frequent fear that his pregnant patients had was that they would lose their " willowy figure ". He described these women as " vain and selfish " in that they did not want to make the necessary personal adjustments for fear they would lose the grace and charm " that they may be convinced are so outstandingly their's.", and he implied that they were not " mentally mature or psychologically evolved ".

This argument is inadequate for two reasons. Firstly, Berger and Kellner brilliantly expose the weakness of such value-laden psychological terms by pointing out that any attempt to use such indices of maturity or stability " overlooks the decisive fact that reality is socially constructed and that psychological conditions of all sorts are grounded in a social matrix ... To bestow some sort of higher ontological status upon these psychological consequences is ipso facto a symptom of the mis- or non-apprehension of the social process that has produced them " (25). And secondly, when the data is set in the theoretical framework which I have outlined here it is placed in a much more intelligible sociological frame of reference. Pregnancy is then seen as a period which entails a crisis of identity, and Sophie's " vanity " is revealed as her preference for maintaining her old identity of woman and wife rather than assuming the new identity of pregnant woman and mother.

It is interesting to compare my work with that of Breen (26). Using the Drawing Completion Test, Breen tried to look at " the meaning of pregnancy and the birth of a first child for a woman's sense of femininity ". Her results surprised her ; they were the exact opposite of what she had expected. She found that : " The well-adjusted women showed a decrease in femininity score from the first to the last testing, while the ill-adjusted women showed an increase. Post-partum, the ill-adjusted women as a group had a much higher average femininity score than did the well-adjusted women. This was true, although to a lesser extent, of the late pregnancy measure ".

Perhaps the reason Breen was so surprised by this result lay in her definition of femininity. She defined femininity as " those qualities which make for a good adjustment to the biological female reproductive

role". Given this definition her test assumes a circular character. Breen analysed her findings in terms of activity and passivity (that is, the ill-adjusted women are more passive, and passivity is mal-adaptive to child-bearing.) But this interpretation would only seem viable if the women themselves defined birth as active.

The fundamental flaw in Breen's argument seems to be that her definition of femininity ignores the cultural aspect. Perhaps any such definition should be taken in two parts, and consider both the biological and the cultural elements. My data suggests that the cultural aspect was by far the more important to my women. Therefore, in ignoring this aspect, Breen is perhaps ignoring the element which women find most meaningful. If we go on and define femininity in cultural terms, her data becomes easily intelligible in terms of my framework. It is then clear that the most "feminine" women are those who are most concerned with retaining their sexually attractive selves. And, as we have seen, for them pregnancy and motherhood inevitably becomes a conflict, so it is understandable that these women have difficulty in adapting to the transition.

(3) Coping Mechanisms

Most of the women became dissatisfied with their body image at some stage of their pregnancy. There is little theoretical work in this area but it did not seem surprising that, given this crisis of identity, the women felt obliged to reconcile themselves to their new body image. In order to do this they resorted to various coping mechanisms. These included attempts at self-persuasion, shifts in perception and redefinition, presentation of accounts and use of strategies such as role distance and cover. Many of these techniques could be subsumed under the general heading of impression management (27), and some (such as defining the "bump" very strictly as the baby, and seeing loss of figure as a temporary thing) have been mentioned in the discussion of the case-studies. This section gives more detailed examples of some of these different coping mechanisms.

Given that they were adopting a new identity which some women did not find entirely attractive, role distance was an obvious mechanism to use. However, only Judith coped with her body image in this way. Role distance is behaviour which expresses "pointed separateness between the individual and his putative role" (28). Coser (29) describes one form of role distance as the pretence of detachment from some status prerogatives in order better to perform a role, and gives as an example the use of humour to deny the conflict of contradictory expectations. This is precisely the form of behaviour Judith used throughout her pregnancy as a way of distancing herself from her pregnancy. For example, she told me how, at the beginning of her pregnancy she and her mother were buying a dress for a wedding. When she saw her reflection in the mirror, much to the sales girl's admiration, Judith burst out laughing.

Here Judith was using humour to cope with what Coser describes as the sociological ambivalence inherent in any status transition: "In learning new roles, a person faces sociological ambivalence twice compounded: he faces different expectations from various reference groups who all have an interest in his growth, yet who define his growth in different ways; at the same time, each reference group expects him to live up to role requirements surrounding his present as well as his future status." The use of humour both highlights and denies this ambivalence. It also makes better role performance possible, in that in the absence of humour and in the face of conflict, performance is more likely to be inhibited. A person with a good sense of humour is congratulated for handling a difficult situation well (hence the sales-

girl's admiration). Judith was able to enact her new self well by adhering to its demands with flexibility. What is being positively sanctioned in these terms is the fact that through humour a status holder is able to face and to resolve social ambiguities. That Judith was using humour as a coping mechanism was shown by the fact that once her pregnancy was over, she ceased to find pregnant women amusing. Pat simply withdrew from contact with others. At the beginning of her pregnancy she told me that once she " showed " she would be reduced to " putting her head out of the window and shouting for my messages. " At eight months she said, " When we go along to Joyce's and that, I'll say to John, ' Wait 'till it's dark. ' He'll say, ' You're off your head. Come on ! ' (giggles) I wouldna say I was really a self-conscious person, because - I was never really bothered BEFOREHAND. I think it's just when I've seen women pregnant, I think it looks TERRIBLE. " Pat's reaction was extreme and unusual.

The final group of coping mechanisms can best be understood in terms of Goffman's concept of impression management - that is, where the subject tries various ploys in order to influence the conclusion the observer comes to about him (30). It is also helpful to adopt Goffman's idea of regions in examining this group of coping mechanisms. He suggests that there are back regions, where people can prepare themselves, and front regions, where they perform. He writes : " The performance of an individual in a front region may be seen as an effort to give the appearance that his activity in the region maintains and embodies certain standards " (31). The standards that these women were trying to achieve were standards of appearance. They believed that they

should look as neat and attractive as possible -- in other words, that they should not seem to "let themselves go". Sheena expressed this common belief when she said, "I think it's nice to see when a woman's pregnant, you know, to have nice clothes. I think there's nothing worse than to see a woman when she's really stout and her hair's horrible. She really looks as though, oh, everything's such a bother, you know. I think it's nice for her to look smart. And not always for her sake, you know, but I think for her husband's as well ... I think it's a shame to let herself go."

A common way of achieving this standard was to resort to camouflage (32), as Maggie acknowledged: "I think you take more care of yourself when you are pregnant, because, I think, well, you feel you've got all this bulk in front of you. You've got to sort of make yourself look more - you know? Well, usually I have all my make-up on. Things that I never used to bother about before. You know, since I got pregnant I feel I'm putting make-up on all the time when I'm going out now. I think to make myself FEEL a lot better. And I usually have my rollers in and that. But I think you do tend to try and make yourself look a lot more attractive when you ARE pregnant. I think, you know, to camouflage, you know, being like this!"

We saw in the last chapter how anxious some women were not to develop "the pregnant waddle". Pat was so concerned that she should not waddle in front regions that she went to the lengths of using an empty street as, in effect, a back region, where, in Goffman's terms, she could, "run through (her) performance, checking for offending expressions when no-one is present to be affronted by them" (33).

She told me : " I think I waddle ! (laughs) I'm saying to John - we're walking along Kilburn road, and there wasn't anybody in the street - and I says, ' Right, I'll walk in front, and you walk behind, and tell me if I waddle, mind ! (giggles) So I'm TRYING to walk straight, and it kills your back. Every time I get home I'm crippled. He says, ' You DINNA waddle ', he says, ' You look alright. ' "

The hospital clinic became an important front region for all the women. Most people take care to wash before they attend the doctor as they are concerned to appear clean and respectable. But to my women, cleanliness was not enough ; they were at pains to prove that they had not " let themselves go ". Gina provided a good example of this : " I think we're all apt to get dolled up to ninety when we go to the Clinic ... I'm having a bath and washing my hair the last minute before I run out the door when I go to the Clinic, so that you're just PERFECT for getting there ! Grant'll say, ' You never even done that for me ! (laughter) What do you want to do it to sit beside a group of women for ? ' " Her performance at the Clinic was aimed at two audiences, the women and the doctor (34), as she explained : " Well, I think if you were to go and everybody was looking nice, except for you, you'd feel terrible. " That is, she would be seen to have " let herself go ". She believed it was important to appear neat and smart before the doctors in order to impress them : " I think doctors sort of get an idea of how you're going to be with kids by the way you dress, and things like this ... I mean, if you go and you're manky (dirty), and no particularly nicely dressed, they're going to say, ' Oh, she's going to keep her kids that way. ' " In this way Gina deliberately resorted to what Goffman calls impression

management based on the belief that good parents keep their children clean and well-dressed.

Summary

During the transition to motherhood two identities, each with its attendant body image, vie for ascendancy. If the woman clung to her old, non-pregnant identity at some point she inevitably came into conflict with her new, maternal body image. It was therefore crucial that mechanisms were developed which enabled her to cope with any perceived discrepancy. In this section I have discussed a number of the more important coping mechanisms which were used. These involved shifts of redefinition, self-persuasion, role distance and withdrawal.

The premise that they must not "let themselves go" (that is, abandon their sexual selves) underlies much behaviour. Many of the techniques they used to realize this aim can be described as impression management.

Conclusion.

These two chapters conclude with a discussion of the implications that the women's perceptions of identity and body image during this period hold for their general body images.

Firstly, the women's conviction that they were "abnormal" during pregnancy points to their over-riding desire to appear "normal." To them, a woman had a "normal" body when it was in proportion - the pregnant body, with its big stomach, was perceived by women like Pat as being decidedly out of proportion because it failed to conform to the hour-glass figure idealized by our society. Goffman (35) has suggested that the notion of "normal human being" seems to pervade the "basic imagery through which lay-men currently conceive of themselves," and he speculates that this notion may have its source in the medical approach to humanity, or in the tendency of large-scale bureaucratic organizations such as the nation-state to treat all members in some respects as equal. My women's rather narrow definition of normal body image might also reflect the fact that because we shut away those people who deviate from the norm (the 'mad,' the handicapped) anyone whose appearance is out of the ord-

-inary becomes very conspicuous.

I have already shown how their imagery reflected their feelings of unwanted conspicuity (cripples and animals in the zoo).As we saw in the discussion on uncertainty,these women were concerned not to make fools of themselves by blundering,and perhaps this fear was related to their fear of being conspicuous because of their appearance. Elspeth feelingly described how her appearance had brought her unwelcome attention: "I remember one time when we were in the High Street,there was this wee kid, a little shrimp,with her Daddy. And she was holding her Daddy's hand and we were waiting for the green man at the lights. And she kept looking round at me. She kept looking at the bump! And she STOOD - she was only about two or three,and I thought she was just going to turn round and say,'Daddy,Daddy,what's that?' but she DIDN'T! (tones of relief) The lights changed and I got going!" In Goffman's terms,Elspeth's "bump" deprived her of her anonymity and "nakedly exposed (her) to invasions of privacy" (36). Perhaps her embarrassment was compounded by the fact that her conspicuous shape was the result of her past sexual activity.

Secondly,all the women wanted to maintain certain standards. At the very least these involved being clean,neat and smart and wearing clothes that fit. Anna,for example,was concerned that she should not become too fat "and horrible with it. I'd like to be able to have dresses and things that can fit me,you know,nice things,like. Because I like to feel that when you're going out,you like to feel nice." In similar vein,Shiela told me that by the time she left work her overall would not fasten. As she worked in full view of the customers she felt self-conscious and described herself as "Big Bertha."

Several women,especially girls like Sophie and Pat,believed it was important to be fashionably dressed.. Pohlenus has shown that there are many ways of dressing fashionably and one's choice tends to reflect one's class (37). He lists a number of categories but none exactly fits my women. However,the categories are continually changing. What my women meant when they talked of fashionable clothes is perhaps best illustrated by contrast; their style was exactly the opposite of the "radical chic"

style which Pohlemus tells us the intellectual "nouveau riche" try to develop. My women's style was characterized more by conformity. Their clothes were generally of the man-made fibre, mass-produced variety that are found in the cheap chain shops. They liked trousers and skimpy tops and shortish skirts, and were concerned that their shoes should be in the latest style. The clothes they liked were therefore the ones which rendered them relatively inconspicuous: they were neither noticeably out of date nor avant-garde.

In addition to being neat and fashionably dressed, a good third of the women believed they ought to look sexually attractive, which to them depended upon having a slim figure. These were the women at the wife/worker end of the continuum. But, just as there are various ways of dressing fashionably, so there are various ways of looking 'sexy' (38). Perhaps looking 'sexy' was what some women called looking "dressed" and others looking "feminine." Being "dressed" seemed to involve being carefully made-up (for example, Anna told me that she did not feel "dressed" unless she was wearing lipstick), and wearing new, fashionable clothes which were "glamorous." Glamorous clothes showed off the figure but not in too blatant a way (for instance, tight trousers and clinging tops were popular.) High heeled shoes were essential to this look. Dainty flimsy underclothes and frilly, pastel coloured nightdresses as well as the archetypal black dress were seen as feminine and 'sexy.'

The epitome of this glamorous, unashamedly 'sexy' look was the film star. This corresponds to Pohlemus' fourth category of the "middle class who seek to be glamorous in the unfashionable fashions of Hollywood." He adds that this is the look which is seized upon in much pornography. The look was achieved by wearing revealing clothes (plunging necklines, see-through material) in soft colours, trimmed with an abundance of lace or frills, completed by a full make-up and a carefully washed and prepared hair style. It took a lot of time to achieve. Jill Tweedie (39) has suggested that "the results of these efforts may not, in themselves, be great attractions to the opposite sex, but they are very obvious signals,

flags waving about, signalling lookie, lookie, I care, I am a sexual object, yoo hoo, big boy."

The four strongly 'maternal' women (Ruth, Alison, Julie and Lynne) remained unconcerned about appearing 'sexy'. As Lynne put it, "Some people probably pay too much attention to regaining their figures and forget they've got a baby to look after." Ruth and Alison in particular merely wanted to be neat and tidy and wear what they thought suited them. The rest of the women fell into the middle; they subscribed to the goal of looking 'sexy' but were less concerned about achieving this goal than the wife/worker women. Joan was the odd woman out. Perhaps her ideas of dress were markedly different as a result of her more student background. Her style more nearly approached that of Pohlenus' "nouveau riche." She wore jeans and long skirts and prided herself upon owning only two or three changes of clothes. Significantly, her approach was characterized by her desire to be different from other women rather than to conform, and she initially tried to use being pregnant as a way of looking different.

It is interesting to speculate why these wife/worker women were so keen to look attractive. Certainly modern consumer society emphasizes women as sexual objects and tries to persuade them that their looks are their fortune (40). For example, romantic magazines of the type read by upper working and lower middle class women invariably present brains and a career as a poor second to good looks. Perhaps Rainwater's study (41) sheds some light at least upon the more 'working class' women in the sample, such as Jean and Pamela. Rainwater noted that his respondents were concerned to make themselves and their surroundings more attractive. He suggested that this was one important way of working class women's alleviating the harsher aspects of their lives. He suggested that some of these women were highly self-conscious (sometimes uncomfortably so), and that "prettying themselves up" reassured them that life was not so bad after all. He also noticed a concern over loss of looks. It would be interesting to learn if more middle class women are equally concerned with appearing sexually attractive, and what their definitions of this are.

CHAPTER SEVEN: EMBARRASSMENT

Introduction

"Embarrassment is a form of social anxiety which is suddenly precipitated by events during interaction; the victim loses poise, blushes, stutters, fumbles, sweats, avoids eye-contact and in more severe cases flees from the situation and (mainly in the Far East) commits suicide. Embarrassment is contagious, it spreads rapidly to the others present. Once a person has lost control this makes the situation worse, as he is now ashamed also of his lack of poise. He is temporarily incapable of interacting" (1).

There are several sources of embarrassment. It can occur when an actor is felt to have projected incompatible definitions of himself, or when his self image is discredited during interaction (2). Loss of poise can also result in embarrassment (3). Loss of poise means a person's lack of control over himself and the situation. That is, in order to avoid embarrassment control must be maintained over space, clothing and the body, props (things arranged around settings and usually not moved during interaction, such as decor), and equipment (things which are moved around during interaction such as physical objects or words). Once embarrassment has occurred role performance cannot continue. Therefore provision for the avoidance or prevention of embarrassment, or quick recovery from it when it happens are of key importance to any society. Actors may avoid embarrassment by contriving to present a face which cannot be invalidated or follow rules of etiquette and skills of tact to avoid breakdown in interaction. For most of my women, embarrassment was a key emotion throughout their pregnancy. If we use Goffman's definition of 'encounter' as an occasion of face-to-face interaction⁽⁴⁾, it seems that there are four main encounters when primiparae expect to or do experience embarrassment. These are their

visit to their G.P. to confirm their pregnancy, their appointment at the Booking Clinic to book their hospital bed, the birth and their post-natal examination. This chapter considers the reasons why some women found these encounters so embarrassing, and discusses the various ways they tried to maintain their poise.

The Confirmatory Visit to the G.P.

The chapter on uncertainty showed how some women felt embarrassed when they saw their G.P. because they were unsure whether they were pregnant. But a few of them felt embarrassed for other reasons. These centred on inappropriate identity, lack of control over equipment or wrong equipment and feared loss of poise, in Gross and Stone's terms (5). Pamela, Brenda and Lynne were single when they conceived and all of them were embarrassed because of this. Because of the stigma society attaches to the girl who is single and pregnant, they felt that in asking the doctor for confirmation of their pregnancy they were presenting an inappropriate identity. This is how Lynne described her feelings: "Oh, I was a nervous wreck! When my name was called out over the intercom I thought, 'Oh!' And my knees shook when I got up. And the thing was, that was when I was really sick. And of course I was nervous at going to the doctor, and when I'm nervous I don't bother to eat. And I was sitting waiting patiently, and I felt really funny, and I thought, oh, I'm going to be sick!"

Because they were embarrassed the girls found difficulty in telling the doctor why they had come to see him. Gross and Stone describe words as one form of equipment and claim that loss of control over equipment such as, in this case, slips of the tongue or sudden dumbness when speech is called for, is a frequent source of embarrassment (6). Pamela described

how she found herself at a loss for words : " Oh ! I was sitting in the waiting room, and I was walking through to her own room , and I STILL didn't know what I was going to say ! I thought, oh, how am I going to put it ? ... I just sort of sat down - I couldn't even look at her. And I just sort of blurted out with it, and I says, 'I'm pregnant !' (hurriedly) and she says, 'Oh, aye.' " Pamela's loss of verbal control was related to her loss of poise, which manifested itself in the way she was reduced to blurting out her message. The doctor's tactful and unembarrassed response steered the interaction back on to a smooth course.

Brenda lost control completely, with the result that interaction broke down and the doctor had to effect a rescue : " Just - trying to tell, you know, that I missed my period, and oh, I couldn't get it out ! You know, the doctor had mentioned it, he says, 'Yes, and you think you're pregnant ?' You know, he says it all for me. (laughter) I was glad it was all over - I was dying to get out."

Maggie was married, but she still found the visit embarrassing. Her embarrassment stemmed from the fact that her doctor was male. She therefore had difficulty in perceiving him as a professional doctor, and the encounter as a medical one. She explained this as follows : " If you're talking to a MAN about personal things, you know, you feel embarrassed. Whereas if you're talking to a lady doctor, you don't ... I think it's because I could always talk to my mother easier than my dad. Well, you know, I could always SPEAK to him. But, you know, with PERSONAL problems, you always turn to your mother. So, sort of, if you're turning to a lady doctor, it doesn't seem so bad, about personal things, than it does with a man."

This image of male doctors is crucial to an understanding of embarrassment during first pregnancy, and it is developed in the next section. Although Maggie was in the minority in feeling embarrassed by her doctor's maleness

at this stage, others soon began to share her opinion as time wore on. Cross and Stone (7) have suggested that devices to ensure the avoidance and minimization of embarrassment will be part of every persisting social relationship. Maggie was making such provision when she asked her husband to school her in the right way to present her case to her G.P. : " I said to Jeff, 'But what will ^I say to him ?' And he said, 'Well, just say that you've missed your period', you know. I says, 'Oh, aye. Aye, I'll just say that then.' (giggle) And if he asks you how long it is since you HAD one, just tell him you were due one ten days ago.' I says, 'Oh, yes, that's right. I was asking him all the things. I was all prepared before I went, you know." However, Jeff had failed to prepare her completely, with the result that she lost verbal control and, like Brenda, caused the interaction to break down : " I just went in and sort of said that I'd missed a period, that my periods were ten days overdue. And I just sort of SAT there. (laughing) And he said, 'Oh, so you think you might be pregnant then ?' I says, 'Yes!'"

Wendy expected to find the appointment embarrassing because she thought that her doctor would examine her, and she was worried lest she would not be able to maintain her poise when her body was exposed to a man. This response was unusual at this stage, but it prefigured several women's reactions at the Booking Clinic, which will be developed more fully in the following section.

And finally, Pamela's self-consciousness was heightened because she took the wrong equipment to the surgery. She knew she had to take an urine specimen, but, being unable to find a small bottle, she was obliged to take her sample along in a coffee jar : " Oh, it was one of they BIG ones! I felt really embarrassed, taking a thing like that." Not only was her equipment wrong for that setting, but because of its size it also carried

overtones of indelicacy and vulgarity.

In conclusion, most women were not embarrassed by their visit to their G.P. basically because they were not asked to reveal intimate parts of their body to the doctor, and were therefore able to maintain their poise. However, they found their appointment at the Booking Clinic far more difficult to handle.

The Booking Clinic

Those women who had not already had an internal examination saw the visit to the Booking Clinic as a major crisis point. This was because it combined two of the most alarming aspects of first pregnancy, uncertainty and embarrassment. Chapter Four showed how uncertainty as to the correct use of space and handling of clothes could lead to embarrassment. This section introduces other, more central, causes of embarrassment, which centre on the two examinations given at the Clinic, the cancer smear and the vaginal examination. (78).

Others have noticed that women are embarrassed by this appointment.

Thompson (8) noted that some women dreaded the Clinic visit because they were so modest, whilst Klein, Potter and Dyk (9) have said : " The initial prenatal Clinic examination was universally dreaded since many patients had been adversely conditioned by stories, feared pain from instruments, or had much anxiety about being examined internally. These concerns were found to deter some patients from coming early to the Clinic and some from attending the Clinic regularly. Recognition of, and some attempt to resolve these fears, at the initial visit to a prenatal Clinic are important aspects in prenatal examination and care." Despite this recognition, there seems to have been little attempt at analysing the reasons why primiparae feel embarrassed.

In her American study of gynaecological examinations, Emerson (10) provides a useful background to this area. Looking at the situation primarily from the doctors' point of view, she shows that for such an examination to be successful, a shifting balance must be maintained between the medical definition and the counter themes. In order to achieve this, the doctor tries to enact the role of the 'detached professional', and he prefers his patient to be 'in play'. That is, she should show that she is attentive to the situation, but is also in control of herself, self-confident and 'neutral' - as if, in fact, " she were talking to her doctor in his office, fully dressed, and seated in a chair ... Her role calls for passivity and self-effacement." However, Emerson does not go on to describe how the women achieve this role. This section describes some of the women's reactions to the examinations and considers why they saw them as embarrassing. It concludes with a discussion of the various ways they tried to maintain their poise and thereby achieve the 'in play' role the medical staff preferred.

For the examination to be successful, it was essential that everyone perceived it as basically a medical encounter, as this precluded embarrassment arising from seeing it in sexual terms. There are difficulties in defining and maintaining the reality of a gynaecological examination as a non-sexual encounter because, as Emerson says, " the site of the medical task is a woman's genitals. Because touching usually connotes personal intimacy, persons may have to work at accepting the physician's privileged access to the patient's genitals. Participants are not entirely convinced that modesty is out of place. Since a woman's genitals are commonly accessible only in a sexual context, sexual connotations come readily to mind. Although most people realise that sexual responses are inappropriate, they may be unable to dismiss the sexual reaction privately and it may

interfere with the conviction with which they undertake their impersonal performance." This was precisely the dilemma which faced many of my women at the Booking Clinic : how could they construct a non-sexual definition of the internal examinations and avoid embarrassment ?

Not all of the women felt embarrassed. Those who were most embarrassed (11) were those who had not had an internal examination before, and, for them, embarrassment and uncertainty as to what the examination actually entailed were closely linked. As Sheena told me later, " I think what it is, at first you don't really know what's going to happen - well, I know SOME girls, if they've had a lot of bother, they're always getting internals to see. But I never had anything like that before. And it was just that that was really the first time I'd ever had anything like that done, and I think that's why I was a bit embarrassed."

In an attempt to reduce their uncertainty and gain general reassurance, some women made a point of asking friends what the examinations were like. Sue told me, " I told my friend, 'I'm going to the Clinic, you know, for the first time.' And I said, 'I got told they give you a cancer smear. DO they ?' You know, just to reassure myself. Some said, 'Yes.' Some said, 'No' But my best friend, she said, 'I got one.' She said, 'I got two,' she said, 'but the first one I got,' she said, 'I felt the first one I got, I really did. But the second one, I didn't feel a thing.'"

Sometimes friends' stories only heightened anxiety. In some ways, indeed, the internal has come to be like labour, a subject which is discussed with other women in rather mysterious tones and which can easily lend itself to embroidery and exaggeration. For example, the hints and allusions Elspeth picked up made her very apprehensive about her visit : " They told me, 'Oh, you'll not feel like coming to work later on. You'll be tired and - ' I thought, 'Hm ! What are they going to DO to me ?'" In trying

not to alarm her Maggie's workmates succeeded only in arousing her suspicions : " Everybody was saying, 'Oh, there's nothing in it, there's nothing in it.' And you always think to yourself, when they're SAYING that all the time - that there must be SOMETHING in it."

It was therefore not surprising that many women felt extremely nervous on their arrival at the Booking Clinic. Pat told me, " NERVOUS ? God, I couldna eat or anything. I was shaking like a jelly. When I got to the hospital I thought, I'd better stop this, I'm getting myself in to a right state - fair plucking up courage walking along the road. But when I got to the door, I could've run a mile ! " And naturally, their nervousness only made it more difficult for them to maintain their poise during their examination. But why did they feel embarrassed ? There are at least three interrelated sets of reasons why they saw the examinations as embarrassing. Firstly, many of the women found it difficult not to define them as sexual encounters. Lynne showed this when she told me how she felt she would never have reached the Clinic if Rab had not been with her : " I'm just too nervous. The thought of what that letter said : ' You'll be asked to get undressed.'

(12) That's as far as I read and then I threw the letter away ... Rab keeps saying to me, 'Nobody's seen your body before, that's O.K., just me.' And I tell him I'm seeing a young doctor and he doesn't mind - it just comes natural to him. But the way I think of it is, I think of what he said to me : 'Nobody's ever seen your body, just me.' "

In addition, another source of intense embarrassment was the fact that the women had to lie with their legs apart in readiness for the examination, and they were acutely conscious of the overtly sexual overtones of this position. Sophie stressed the undignified nature of the way they had to lie. In his discussion of maintaining face, Goffman has shown that when people have scruples about "postural things, with expressive events derived

from the way in which the person handles his body", one speaks of dignity (13). Sophie said, "It's ^{just a} very undignified way to be lying, anyway, apart from anything else. You obviously can't feel very dignified when you're lying in THAT position." By this, she was implying that it was hard for her to maintain face when she was forced to relinquish control of her body.

Sheena's and Wendy's comments focused on the sexual nature of the encounter : " You never put your legs right over in front of a man before ", and, " Just the thought of anyone touching me there - just made me squirm."

Secondly, as Lynne's comments have already implied, the women's image of the doctor was crucial in determining whether or not they felt embarrassed (14). It was significant that Lynne mentioned that she was seeing a young doctor. Goffman (15) has suggested that " things go well or badly because of what is perceived about the social identities of those present".

During interaction each person is expected to possess certain attributes, capacities and information which together fit into a self that is at once coherently unified and appropriate for the occasion. Through his conduct, the individual projects this acceptable self into the interaction (although he may not be aware of it), and the others may not be aware of having so interpreted his conduct. At the same time he must accept and honour the selves projected by the other participants. In sum, the elements of an encounter consist of effectively projected claims to an acceptable self and the confirmation of like claims on the part of the others. The contributions of all are oriented to these and built up on the basis of them. It is the women's reluctance to accept the professional self that the young doctors project into the interaction that heightens their embarrassment during the examinations. There are two main reasons for their reluctance.

Firstly, their preconceived images of doctors tended to be of older men,

as Sophie explained : " Everybody's got their own image of what a doctor or a minister or whatever looks like. I mean,you imagine doctors as middle-aged,you know,fatherly doctor types,greY hair receding at the temples,glasses,no-nonsense,brisk manner. Then you're confronted with one who has longish hair,flared trousers,trendy tie - well,they're coming away from your set - at least,MY set image of what a doctor should look like. And that knocks me out for a wee while. You don't look upon them in quite the same light. So I feel that bit more ill at ease when the doctor is young. I prefer to have someone older."

Secondly,the doctors' youth,together with their fashionable clothes and informal manner prompted the women to see them in personal terms,and in relation to themselves (" he could be my husband,I could be his wife.") They saw the doctors as men,and as men who were contemporaries. Once this image had been established,it was only too easy to imagine that these men might well be susceptible to the sight of the naked female body,with the result that the women felt embarrassed at so 'immodestly' exposing themselves to young men. Jean emphatically saw young doctors first and foremost as men : " They say,'Dinna be embarrassed at showing your bodies,we're doctors.' But,I mean,if I was standing here,and a strange man like your husband walked in,and I was standing naked,my face would be as red as anything. And the same if you were naked. You dinna worry about standing naked in front of your man,but you wouldna like to stand naked in front of mine if you hardly kenned him. Well,it's the same thing at the hospital; you dinna ken them either."

It was therefore easy to see why many women at this stage shared Sophie's preference for an 'older' (i.e. middle-aged) doctor. As Pat put it," Well, they're the same age as you whereas if you get a right old man,you feel he's had plenty experience,sort of style,it'll no bother him. Ken what I

mean ? " Perhaps what they did mean was that during his first examinations, they expected a doctor to respond to the sight of a naked woman's body; but after he had examined several, they expected his sensibilities to become so dulled that he would come to look upon her body purely from a medical point of view - as a detached professional.

The women's attitude towards their doctor was closely related to their self image, and this constitutes the third aspect of their embarrassment. The self that they wanted to project into the encounter was not the one most calculated to sustain the medical definition of the situation and thus spare them their embarrassment. This was partly because they still saw themselves as individuals in a unique situation (Deutsche (16) has said that primiparae have the feeling that THEIR pregnancy is something extraordinary.) Sheena explained : " I think you probably think you're the only person in the world having a baby, and when you go there (giggles) you see all these other folk ! " But it took time for them to redefine their self image in the light of this realisation; until they could do this, they continued to perceive the encounter in very personal terms, and remain vulnerable to embarrassment.

The women were also projecting the 'wrong' self into the encounter because they still regarded themselves as sexual beings. As we have seen, their sexual identity was intimately related to their body image. When they attended the Booking Clinic, most women had not noticeably put on weight and so did not 'show' that they were pregnant. Therefore their sexual identity was still strong. But when they projected their sexual selves into the encounter, this meant that they were implicitly perceiving it as sexual, and so they became acutely conscious of their bodies and the fact that a man was looking at them. As Darwin has said, " It is not the simple act of reflecting on our own appearance, but thinking what others think of us

which excites a blush " (17). This completely threatened the medical definition. In order to save the situation, another, non-sexual self had to be projected, but for most women the examination was not long enough for them to redefine themselves and thereby the nature of the situation. Therefore they were left feeling embarrassed.

However Goffman (18) has shown that embarrassment can have a positive social function : " By showing embarrassment when he can be neither of two people, the individual leaves open one possibility that in the future he may effectively be either. His role in the current interaction may be sacrificed, and even the encounter itself, but he demonstrates that, while he cannot present a sustainable and coherent self on this occasion, he is at least disturbed by the fact and may prove worthy at another time. To this extent, embarrassment is not an irrational impulse breaking through socially prescribed behaviour, but part of this orderly behaviour itself." In the following sections we shall see how the women did indeed "prove worthy" at another time, as we watch how they progressively divested themselves of their sexual selves. The visit to the Booking Clinic is important here in that it forms the first stage of this desexualization process.

Another important aspect of their self image was modesty. Some women were extremely concerned to maintain their reputation as modest. MacCurdy has shown that modesty is intertwined with sexual shame (19). Weinberg has defined sexual modesty as a form of sexual reserve, or a communication of non-availability for sexual interaction (20). This meaning resulted from the actor's following the dictates of sexual propriety. - the common-sense constructs of proper or 'decent' behaviour. Perhaps these women were concerned to maintain their modest self image (and be seen to be modest by the hospital staff) because if they failed to do so, they believed that they might be accused of initiating sexual interaction. (Emerson (21) has

shown the difficulties involved in making an "appropriate show" of modesty. Patients should be neither too modest or too immodest.) Therefore, perhaps some women perceived embarrassment as the right response during the examination as blushing "proved" (22) their innocence.

Pat said of the internal : " I just felt my face going scarlet from the neck up ... God,I could've died. Oh,it is embarrassing,I'm no caring what anybody says." She attributed her embarrassment to her upbringing : " It's maybe me. I mean I'll no get undressed in front of my man. It's maybe just the way I've been brought up. We were never allowed to undress in front of father,we'd go to the bathroom,or you'd go to your room - ken what I mean ? I've always been like that. Some people can prance around in a low-necked dress,well,I'd be dead embarrassed to do that."

Modesty can also be seen as a pattern of deference (23),that is conducting oneself with good demeanour is a way of showing deference to those present (this could be called 'deference through non-initiation' of sexual overtures.) This interpretation of modesty points to inequalities in the social structure,since patterns of deference suggest the relative positions of individuals in the social hierarchy. This meaning of modesty could be said to be particularly apposite where doctors and patients are concerned.

Emerson (24) has described how the staff like the patients to behave : " The self must be eclipsed in order to sustain the definition that the doctor is working on a technical object,not a person." The self image the women projected into the encounter made it very difficult for them to behave in this way,and showed the need for a variety of coping mechanisms.

Coping Mechanisms

Embarrassment threatens the encounter by disrupting the smooth transmission and reception by which encounters are sustained. It can momentarily incapacitate an actor as an interactant (25), as Pat found : " I was that bloody embarrassed, I didn't feel anything. I didn't even hear what he was saying to me (26). I just thought, oh, God, hurry up and get away. Get lost. Hurry up and finish." It is understandable that when embarrassment occurs, the flustered individual will make some effort to hide his state from the others. The women resorted to various manoeuvres in an attempt to maintain their poise. The main aim of all these manoeuvres was to reinterpret the examinations in a non-sexual light (and therefore non-embarrassing). One of the most popular tactics was to take refuge in a phrase which was common currently among the women in the area : " When you're pregnant, you leave your modesty at the door and pick it up on the way out again." This phrase neatly encapsulated the desexualization process involved in pregnancy. It served as a coping mechanism by offering reassurance (others had gone through the transition), and in virtually authorising them to relinquish their modesty during this period.

Another manoeuvre involved constructing a less threatening image of the doctor. The doctor could help promote the redefinition by his behaviour. For example, in the sixteenth and seventeenth centuries, the man-midwife apparently crawled on his hands and knees into a darkened room. Pare operated blindly under a sheet attached to the neck, whilst in the 1870's modesty was assumed to have been saved by having vaginal examinations performed whilst the women were standing (27). More recently, American doctors have sometimes used euphemistic terms to minimize the sexuality inherent in the situation (28).

Several of my women constructed a new image along the 'nice doctor' lines,

where a "nice doctor" was one who chatted and joked with them. One implication here might be that the doctor, by appearing unembarrassed and unembarrassable, gave them leave not to feel embarrassed themselves (29). Another might be that a "nice doctor" seemed decent, respectable, clean-living and generally far removed from any "Hospital Romeo" image. (For the difficulties some women experienced in maintaining a professional image of the doctor in the face of his very unprofessional behaviour see the section on the post-natal.)

Despite their difficulties in accepting a young doctor as a professional many women tried hard to persuade themselves that he was "only doing his job" and "not taking any particular notice of me." Some seemed to succeed in convincing themselves that "a doctor is a doctor" (and therefore only doing his job), but Sophie clearly expressed the ambivalence felt by others: "O.K., they're DOCTORS, and I mean, it's nothing new to them. If you've seen one you've seen them all according to them, and there's just nothing new. But they're still - they're still HUMAN, obviously, and have ordinary feelings. So, to me, they can't look at the naked human body and be completely detached from it. They're bound to say, 'Ugh,' you know, 'What a figure this one's got,' or whatever, to THEMSELVES. I don't suppose it suits them any better than it suits you. THEY just have to keep themselves detached from what they're doing. And they're as ill at ease as you are." Thus in Sophie's eyes, the two images of doctors as professionals and as men juggled for ascendancy.

The fact that the girls' image of their doctor related to their self image had implications. For example, they were more likely to be able to see their doctor as a disinterested professional if they saw themselves as simply one of many pregnant women instead of a special individual in a unique situation. Once this shift in self image occurred it was easy to fall

back on the coping mechanism of,"Och,they're doing that every day,ken, they've got hundreds to do",and defuse the highly charged personal and sexual atmosphere. Julie experienced this shift; before she had attended the Booking Clinic,she saw herself as "the only woman who'd ever been pregnant." But her feelings changed on arrival : " I THOUGHT I would have been embarrassed - I THOUGHT I would have been. But actually,once I got there,I wasn't. Because everyone else was the SAME. All the other pregnant women there,they were all going through just the same as you, and you tended not to think about it then,because you thought,well,to the people,it's just like another bit on the conveyer belt. You know, it's not really an individual at the Booking Clinic,because there were so many people there. You just go from one to another until you actually go into the DOCTOR (i.e. for the internal examination). And that was the bit I was dreading. But once I was there,you were in quick and out,because they're waiting for the NEXT one. So,you know,if you were just the ONE of you,and perhaps going to your G.P.,I think it would have been worse." Of course,not all hospital doctors are male,a fact which spared Lynne her embarrassment. She invested all her energy into hoping that she would get a lady, doctor : " You go through to the cubicle,and wait again until your name gets called again. And then you've got to wait again when you come out. So it's all waiting,and it's pretty nerve-wracking. The cubicle was so bare. It was just like a little toilet. Four blank walls and a bench to sit on. And a mirror. So I looked at myself in the mirror,and I thought,'Oh,what am I going to do ?' I was thinking about which doctor I was going to get ! I saw all male doctors,and I thought,oh,no ! And I saw this one female doctor on her own,and I thought,'I wonder if I'll be lucky enough to get her ?' And I was,actually."

But female doctors were not always the solution. For one or two women,

like Shirley, the idea of a woman administering such an intimate examination held overtones of lesbianism : " I dinna like women poking me. I mean, that sounds stupid, but I'd rather have a man than a woman. I suppose I just think it's - well, maybe no wrong, but to me, I just dinna like the idea of one woman poking another."

Some women were able to reduce the sexual overtones by redefining the examination itself. The 'nice' doctors could be instrumental here; by joking and chatting inconsequentially during the examination they gave the impression that it was just an ordinary, everyday event (30).

Alison's doctor explicitly redefined her cancer smear test as an investigation to discover the size of her baby - " And I thought, oh! (smiles rapturously) thinking all nice, ken. And then after it, he said, 'Actually it was a cancer smear test we were giving you.' " The success of this type of manoeuvre clearly depends on the warmth of the woman's attitude towards her foetus.

By now it should be clear that this whole area is a delicate and complex one, involving subtle inter-relationships between the woman's self image, her image of her doctor and her perception of the meaning of the examinations themselves. The Booking Clinic is a crisis point for many women simply because it is there that all these strands come into conflict for the first time, and they are often unable to redefine their images quickly enough to preclude discomfort and embarrassment.

One of the basic reasons behind the prevailing embarrassment would seem to be the fact that many women were not clear as to why the internal examination was necessary. And so, in this vacuum of meaning, the obvious sexual connotations were able to proliferate. Oliver Gillie (31) has pointed out that many women complain that the vaginal examination is too often painful and humiliating : " It can be unnerving for the coolest

woman to have a doctor insert a large cold instrument into her vagina."

In the same article he quotes Ellen Frankfurt, author of 'Vaginal Politics', as saying, " Nothing comes closer to an unpleasant sexual act."

But most women do not see any other viable way of interpreting the examination. It might be helpful if the medical reason for the internal was made clearer to them so that they could see its necessity in medical terms. This would offer them an alternative set of meanings with which to understand it. It seems significant that the women who during their pregnancy had to have internals for other reasons (e.g. appendicitis) said they were not unduly worried by them because they knew that there was "a reason" for them.

I wonder how many women share the perceptions of Shirley, herself already a mother of three : " I don't really think it's necessary. I mean, why do they do it ? Let's put it that way. I mean, they KNOW you're pregnant, so they're no doing it to find out if you are or aren't pregnant. I mean, why bother ? I had two perfectly healthy girls and normal pregnancies, and I never was examined once. Not THAT way. So why bother ? They give you a smear as well. Well, I mean, I think to myself, I suppose I'm O.K., but then, I mean, that young girl that my sister-in-law knew, she was what ? Just six weeks when she went to the hospital - had a miscarriage the same night. I mean, all the poking about. I mean, anybody who's prone to anything like that, it must BE bad mustn't it ? I mean, it must be terrible for somebody who waits ages to get pregnant to go up there and end up losing it - through them ! "

Ante-natal Care

To their surprise, most women did not find their Ante-natal care embarrassing. There were several reasons for this. Every social transaction requires

the manipulation of equipment. By now the girls were much more familiar with the procedure, and so were better able to handle their equipment, particularly their clothing. By this time most of them had learnt exactly how far they should strip, although mistakes still occasionally happened. Wendy's misunderstanding of what was wanted carried overtones of embarrassing immodesty and sexual invitation : " But the second time I went for my ante-natal, nobody had SAID anything to me. (I don't know if they thought it was just my second time.) And, of course, I stripped right off again (laughs). Oh, and I went through - this is what embarrassed me, though, because, well, everybody else was still in their clothes and I had stripped off ! I think the doctor walked in and thought 'Oh ! What's going on here ?' " In effect by mishandling her clothing, Wendy had reinforced the sexual nature of the encounter, and eroded the medical definition. Secondly, they found the type of care less threatening, as it did not regularly involve internal examinations. Thirdly, they had now had time to redefine their images of themselves and the doctors, and were able to attach some meaning to the medical procedure. For example, Anna said, " I think at first I thought I was going to be embarrassed with young doctors, mind. Well, me being sort of ages with them, you know, I could be their wife, you know. But I mean, you're lying there showing a big belly ! (laughs) But they're no like that at all. They're just - nice, you know ... I think I would be a wee bit more embarrassed if I wasna pregnant, like. Like BEFORE you had a baby, you know. I think I would maybe be a wee bit more embarrassed getting examined by such a young doctor. But being pregnant, and knowing THAT is what he's there for - that HE IS an obstetrician - not just an ordinary doctor, he's a baby doctor. (Well, that's what I call them, any way, baby doctors.) Well, I'd rather be with him than an ordinary G.P. I canna really explain how they put you at your ease. Och, I suppose

they must because every woman they look at is pregnant, aren't they? They never look at anybody who's NO pregnant. Except maybe your post-natal examination, you know. I mean, every woman they touch IS pregnant, so it doesn't matter." In her last interview she added, "Well, you dinna mind when you're pregnant, because there's a reason for it, you know. There's a BABY inside you and you know that the doctor's there in order to bring that baby out of you. So your body is no a - I canna explain it - it's no a feminine piece of machinery. It's just- your body's only an encasing of a baby. The doctor's no interested in what your body looks like. You may be covered in scars or love-bites or anything - he wouldna look at you. He's only bothered about the baby, you see."

Jean gave me the following explanation as to why she was not embarrassed: "I dinna bother, because I know it's just their job and that they've seen a thousand women just like me. Every minute of the day, so it doesn't matter to me about them. We had a young fellow last time - he'd be in his twenties, he wasna any older than that, ken, he was just young. But he was nice enough, he didn't MAKE you feel embarrassed. But I mean, they're no really actually seeing anything, are they? It's only your stomach they're looking at. It's no as if you're getting internals or anything - no now."

From Anna's comments we can see that she no longer regarded herself as a sexual being. Her new, non-sexual image underlay all her remarks but came out most clearly when she described her body as no longer "a feminine piece of machinery" but only "an encasing" for the baby. She had managed to redefine her self image partly in the light of her new body image (her "big belly"), and partly because she had stopped seeing herself as unique in being pregnant. Because she had redefined her self image in this way she was able to believe that the doctor was not interested in

her from a sexual point of view.

By this time the women had had time to redefine their doctor as a professional ("it's just their job"). No doubt one of the reasons why they managed to achieve this redefinition was because they had got used to seeing young doctors working in the hospitals, and their youth gradually became less of an issue. Indeed, Anna had begun to see hospital doctors as superior to her G.P. because she saw them as specialists; her labelling them "baby doctors" suggested both their competence and their raison d'être, whilst underlining the theme that they were interested in her baby and not in her body. Both Anna and Jean maintained their poise by holding on to the "nice doctor" image. Lynne took this image a step further. She re-defined her image so radically that instead of feeling threatened and embarrassed by young, male doctors, she came to see them as 'heart-throbs' (32): "Well, the last two have been young. One was quite a heart-throb, actually. So he was ! I came out all starry-eyed ! " Klein, Potter and Dyk (33) have discussed the changes in sexual personality that occur during pregnancy, and they quote research findings that suggest that in late pregnancy there can be a lack of modesty coupled with an increase in exhibitionism and erotic attitudes towards the obstetrician. Perhaps these new feelings relate in part to the fact that the woman has divested herself of her sexual identity, and as she therefore regards herself as being 'out of play' she considers it safe to indulge in erotic feelings towards her obstetrician.

Anna now believed that there was sound reason for her ante-natal care; she believed it was for her baby's sake, and she saw it as a necessary prerequisite to her baby's birth. Perhaps as the birth drew near the women were also more able to put the ante-natal procedure into perspective. Certainly Pat was : " At first I was really AWFULLY embarrassed. Ken, it

was oh ! I thought it was the end of the world, sort of style. But no now. (laughs) Oh, you wouldn't NEED to be - at the birth you'll be showing a lot more than that, eh?"

In the section on the Booking Clinic we saw how important it was to some women that they should continue to see themselves as modest. For these women, their lack of embarrassment during their ante-natal care threatened their modest selves. Wendy was a case in point. Instead of redefining herself as most women did ("when you're pregnant, you leave your modesty at the door"), she redefined her concept of modesty. She had seen it as an absolute concept; now she saw it as a relative one. When I asked her if she felt embarrassed she replied, "No - although I think I still am modest. You know, when you see some of the girls - some girls are not sort of - very modest, you know. I suppose everyone's just brought up in a different way." The development of Wendy's thinking will be discussed in a subsequent section.

In conclusion, once they had been to the Booking Clinic, the women tended to be unembarrassed by their medical care. They were able to carry off their visits with poise because their desexualization process was almost complete; they had accordingly redefined their images of the doctors and were now able to give meaning to their treatment.

These visits to the ante-natal clinic seemed to perform a positive function as regards embarrassment. Gina explained this function when she told me why she was not embarrassed by her labour : "Of course, you've got all those weeks before, at the clinic, when they're knocking you about. (Not a very nice expression !) ... Slowly but surely it gets you used to it. I mean, the first time you go to the hospital, it's after three months. Then, after that it's once a month. Then it's once a fortnight, then once a week, 'till it eventually gets down to you're actually IN the hospital, and it's

every DAY that you're getting - tampered with, you know. So you're slowly getting used to it." Gross and Stone (34) have said : " It may well be that every move into an established social world - every major rite de passage - is facilitated by the deliberate perpetration of embarrassing tests of poise, identity and self-knowledge." It is interesting to speculate whether the examinations at the ante-natal clinic form part of these "embarrassing tests".

The Birth

Many women were apprehensive about the birth because they expected it to be embarrassing. They envisaged two sorts of embarrassment : firstly, they were frightened that the pain would be so severe that it would force them to lose their self-control in a way which they would later find embarrassing; and secondly, they expected to be embarrassed because they knew that during birth they would have to expose their genitals. This section describes this second aspect of embarrassment. Chapter Eight describes the first. Ford (35) has pointed out that in all societies women are taught not to expose their genitalia to men. Primitive societies have avoided violating the norms of modesty by prohibiting men from witnessing childbirth, but modern society is not so circumspect. But to their surprise, none of the women found the actual delivery embarrassing. This section considers the reasons why the delivery was not regarded as embarrassing, and discusses why certain preliminary stages during the labour were found, in contrast, to be acutely embarrassing (36).

(a) Preliminary Stages

The embarrassment during the early stages of labour can best be understood in terms of Goffman's "unmeant gestures" (37) (here, loss of muscular control), and the exposure of intimate parts of the body in front of others.

Both these types of behaviour are embarrassing because they are not socially sanctioned.

For example, Jean found the breaking of her waters acutely embarrassing because her body was exposed in full view of young male doctors. Her difficulty in perceiving them as disinterested professionals was increased by the fact that they were not working, merely observing: "It was a lady doctor, like, but there's young men there - well, they put you up in stirrups, right? So I felt like a big hunk of mutton. I did, I felt right embarrassed. 'Cos the fellows are the same age as Duncan. And they came walking in and they just sort of looked, and laughed - smiled to each other, ken. Standing talking away while she's doing the inducing. You CANNA leave your modesty at the door. You're bare from the ankles right up to the chest. Now you're LYING there with your legs wide open and you're all shaved, and there's young men walking into that room, and as soon as they walk in the door they're looking right up you. And how would YOU feel? I felt sick. I just thought, 'I hope I never meet you in a pub, sonny.'"

Maggie found the shaving (38) embarrassing: "Oh, I found it embarrassing. I don't really know why. Just because you're getting everything shaved off. I think it's just people looking at you, you know. And getting shaved. You never think of yourself as getting shaved. I mean, maybe your arms and your legs, but actually getting shaved THERE, you know."

Hamilton (39) reported that some of her respondents expressed a fear of "animal behaviour" during labour - that is, loss of control of their bowels, vomiting and "gushing" of waters. This is the sort of behaviour which Goffman (40) calls "unmeant gestures." These gestures can be construed as embarrassing because they "force an acutely embarrassing wedge between the official projection and reality." And, moreover, momentary loss of muscular control can be perceived as conveying disrespect.

For instance, Wendy was embarrassed by her flatulence during labour. She had eaten heartily on the day she was induced but had not been given an enema. She told me, "And it was quite funny too. Well, when I was taking my contractions, when they were getting heavier, I started passing wind through my bottom (nervous smile). And I kept saying, 'Oh, pardon me, pardon me!'" The medical staff helped spare Wendy her embarrassment by redefining her "unmeant gesture": "And the doctors and the nurses were in fits, and the doctor says to me, 'What are you worrying about?' he says. 'Don't worry about that. That's a good sign, that's the baby pushing its way out.' I didn't know that, of course." Not only did Wendy come to see her flatulence as a positive sign (almost a stage transition) during the birth, but she also came to regard social niceties as being absurdly out of place: "I kept going, 'Beg your pardon, pardon me,' trying to be so well mannered! It's not really a thing of etiquette, birth. It's a messy thing."

Deutsche (41) has remarked how often the breaking of the waters brings the infantile fear of bedwetting to the fore. Helen described her experience as follows: "It just runs away from you and you can't do anything to stop it. Lying in the bed certain times, it seemed to KEEP coming away from me, even when I was having contractions and that. And I felt as if I was lying there wetting the bed. I kept sort of saying, 'Is this alright?' But they're saying, 'This is what HAPPENS,' you know. To me it was new. I thought, I can't hold this in, it's just running away - THAT feeling, you know. I didn't think that would happen. I thought it would just run out and that would be it, you know. Finish!"

After their waters had been broken, the women were given an enema. This deprived them of control over their anus with, in Maggie's case at least, the following embarrassing result: "Oh! It was TERRIBLE. It makes you just

RUN to the toilet... I found it really embarrassing. Because - the NOISE it makes when it's - everything's - it's just like pools of water just coming from you, you know. And it's just everything. It cleans out your bowels and everything. And I thought, oh goodness! You know, the noise it actually makes when everything's just running. You can imagine, it's all getting poured into you and it all just runs back out of you, and I'm saying, oh goodness, imagine, if anybody is listening to this, you know. And I was REALLY EMBARRASSED with that... And of course, when they gave me this and I went to the toilet I just sort of made it in TIME, and some of it went on the floor and I was scared to go out and I'm trying to wipe it up. And the nurse is saying to me, 'Now don't worry,' she says, 'Just leave it. We'll clean it up, you're not to do anything like that.' But oh, it was really a horrible thing, that."

But perhaps these embarrassing preliminaries have a positive function to fulfil. Gross and Stone (42) have introduced the concept of buffer zones around settings which prepare newcomers and reduce the likelihood of their embarrassing both themselves and others. It may be that these preparations for birth act as buffer zones to the delivery and make it much less embarrassing than the girls had expected. They certainly performed this function for Kathleen. She described how, during her labour, she was divested of her embarrassment by degrees. She had found the first preliminary (shaving) embarrassing, but she had been unembarrassed by the doctor's breaking her waters because "You've already been SHAVED, you know." The breaking of the waters in turn served as a stage transition as she went on to explain: "But after they break your water, you see - it's a DOCTOR" (i.e. a man) "that breaks your water, you know. And after that you never bother WHAT happens to you!" Therefore the cumulative effect of the "embarrassing tests" and the buffer zone effectively reduced the

embarrassment of the actual delivery.

(b) Labour and the Delivery

This section looks at why the girls were not embarrassed by their labour and delivery. In order to understand this fully, it is important to see labour as a process during which they progressively lost their embarrassment. (Elspeth illustrated this when, describing an embarrassing incident in the early stages of her pregnancy, she added, " This was before I was right into labour, before I had given up all sort of CARE.")

The reasons why they were not embarrassed fall into five main groups. It is simplest to consider the most straightforward ones first. Firstly, as we have seen, the girls had grown used to examinations. As Anna told me, " You've went through nine months of ante-natal, and you're always examined. And by the time you're having the baby, you're examined EVERY WEEK, if not more. And then, when you have the baby, you're examined ALL the time you're in labour. You're used to it, you think nothing of it." The second group of reasons hinged on the ways the women now defined the birth. Because they were now able to give it a definite and positive meaning, their embarrassment was considerably diminished. For example, Sophie saw birth as " the most natural thing in the world ", whilst Anna told me that she was unembarrassed " probably because I knew I was going to have the baby. It was all for a cause." Others found that the labour so preoccupied them that they were left with no time to feel self-conscious, as Sheena explained : " I think you're just so concerned about getting the baby born, you've really no got TIME to be embarrassed. You know, you're wanting everything by and you never even THOUGHT about being embarrassed. Not at all."

Thirdly, other emotions drove out embarrassment (43). Probably the most important was pain. As Sophie said, " When you're in labour and you're

suffering pain,well,you've got that to contend with,anyway. I think it's completely different if you're lying there,full of beans and bright as a summer's day,and they're doing their prodding and poking THEN." Some women let sleep drive out their embarrassment,and others found that the drugs they were given effectively relieved them of all traces of embarrassment. But perhaps the most important reasons centred on the women's self image and image of the medical staff. As these images are so interdependent,it is easier to consider them together.

The birth represents the culmination of the desexualization process. Far from perceiving themselves as lone individuals in an unique situation,the women now felt 'I'm not the only one',and 'The staff have seen lots of others like me'. An important stage transition here was the taking off of clothes and the putting on of hospital garments. To some extent this change of clothing represented the change of identity which was taking place here,as Julie remarked : " Just before I went in,I thought,I shall never stand it ! ... I shall want a paper bag for my head,you know. But once you're in,that's it. Once you've got all your clothes off,and you've got their little nighty on,you don't think about anything else after that." So,by the time of the birth,most women felt that they had lost their sexual identity. Sophie described how she felt : " Well,you've just got to lie,there's nothing else for it. And you think,well,they've got to examine you,and,as I say,when they've seen one,they've seen them all. It doesn't mean anything at all to them. They're not looking at you from a sort of MALE point of view,and thinking,'Oh,this is a naked female body lying here.' It's just a medical specimen to them,as far as the men go." In a more paradoxical way,Anna's experience also suggested that she had divested her sexual identity during labour. She had formed a liking for a particularly good-looking doctor during her ante-natal care,and she saw

him again just as she was going to the delivery room. She told me," He passed the door, and he looked at me, and I looked at him. And I thought, I wonder if he's going to be in the delivery room. Because I felt that he was so nice, that I liked him so much, that I'd be embarrassed if he delivered my bairn ... (Because) I felt I liked him no as a doctor. I thought he was great looking, you see. If I hadna been married, and ME hadna been married, I would have quite fancied him, you see. So I would have been embarrassed, you see, ken. You dinna look very elegant, lying there with this horrible bulge, you know, with your legs wide open, and - oh! (distastefully) ... So I wouldna have felt very nice. I mean, if I fancied him, and I thought he might fancy ME, he certainly wouldna fancy me anymore if he saw me in that state ! " Here Anna did not feel embarrassed because she felt she was a sexual being who was being violated (as she felt during her visit to the Booking Clinic and at her post-natal), but because she defined her relationship with this doctor as partly a sexual one, and during labour she felt unable to present a sexually attractive self. Her embarrassment stemmed from appearing in the wrong identity.

Tied in with their self image was their perception of the doctors as disinterested professionals (the phrase, 'It's their job' reflected this). Maggie was not self-conscious because she saw the staff's behaviour as having a purpose : " You couldna really care what they're doing to you at the time ! Because you think to yourself well, they're only trying to do it to help you. To help the baby come, you know." Several women told me that " the staff don't make you feel embarrassed ". Joan had expected the birth to be embarrassing, but when it happened, " it wasn't, the situation wasn't embarrassing. In fact it was really good. They must have done it really well." She thought she was not embarrassed because, " THEY were all looking forward to it as well. Because the midwife, afterwards, she said,

'Let me have a wee cuddle,' and everything. She seemed to LIKE delivering babies." Sheila brought up the "nice doctor" image again: "You never feel embarrassed at all in hospital. I think it's because everybody's so nice. For instance, after the doctor was stitching me up he was blethering away to me and he says, 'Do you fancy a double gin and tonic?' (laughs) I says, 'Oh no!' But I mean, they were right down to earth." Confidence in the unembarrassed and friendly behaviour of the doctor helped Sheila overcome her own embarrassment (44).

Interestingly enough, Ruth felt constrained not to show any embarrassment incase this embarrassed the young student doctor who was delivering her baby. Embarrassment is infectious and incapacitates the actor from continued role performance. Therefore, as Gross and Stone (45) have shown, great care must be taken in delicate situations that it is not allowed to spread among the role performers.

In short, although the preparations for the birth were sometimes seen as embarrassing no one found the delivery itself embarrassing. By that time the women had grown used to intimate examinations and were able to imbue birth with a very definite meaning. They had come to see the doctors as professionals rather than as men, and themselves as unattractive. The advent of pain was instrumental in driving out any lingering embarrassment. And so, at this stage, embarrassment was generally seen to be out of place. As Julie said, "It would be impossible to feel embarrassed because if you did, I don't suppose you'd ever have the baby, would you?"

The Postpartum period

When I saw the women eight weeks after the birth I found two markedly different reactions. Some remained unembarrassed by internal examinations; others had regained their embarrassment at some point during this period

and found them intensely embarrassing. The first set of women were able to remain unperturbed because they felt that they had had so many internal examinations that they had "got used to them." As they became less sensitive to gynaecological investigations they came to see them as less threatening and more familiar. But although the other group of women agreed that this argument was valid, it failed to provide them with a total coping mechanism.

It is difficult to say categorically why some women reverted to feeling embarrassed but others did not. However, one important factor would seem to be the type of coping mechanism a woman relied upon during pregnancy to help her through the medical procedure. The way she reacted to her examinations may well have reflected her background and degree of embarrassment about sexual matters in general. As we saw earlier, a gynaecological examination can easily be seen as a potential sexual situation. In order to avoid embarrassment, a woman had to find some way of denying this implicit sexuality. There seemed to be two ways of doing this. One was to say that this was primarily an examination of the foetus; the other was to believe that the medical staff were not defining it as a sexual encounter. Accordingly, the first set of coping mechanisms emphasized the baby, whilst the second stressed the role of the doctor (in terms of his being a professional, detached and used to seeing naked bodies) and the image of the self as being one of many.

If the coping mechanisms used during pregnancy focused mainly on the baby it was likely that the woman would feel embarrassed after the birth. Anna provided a good example of this. As we saw earlier, most of her coping mechanisms during her ante-natal period centred on the baby. She emphasized the fact that she was pregnant, and believed that her pregnancy gave the doctor his "raison d'etre" ("but being pregnant, and knowing that THAT

is what he's there for..." In her eyes the doctor was transformed into the obstetrician, "a BABY doctor," who was allowed access to her body because of her foetus: "Well, you dinna mind when you're pregnant, because there's a reason for it, you know what I mean? There's a baby inside you, and you know that the doctor's there in order to bring that baby out of you. So your body is no a - I can't explain it - it's no a feminine piece of machinery. It's just- your body's only an encasing of a baby. The doctor's no interested in what your body looks like ... He's only bothered about the baby, you see." Anna moved outside her baby-centred mechanisms when she added that the doctors were "nice," but she never developed this line of thought any further. And so, in the main, she relieved her embarrassment by understanding the examinations, her body and the doctor in terms of her baby.

Therefore, when she was given her post-natal examination, it was not surprising that she felt embarrassed. Without a baby inside her, her former coping mechanisms were useless, and she had failed to develop any alternative ones. As she could no longer take refuge in the fact that her body was a pregnant body, she was overcome by the realization that she had regained her sexual identity: "You've got your own clothes back on again and you feel feminine again. You feel as you USED to feel. Then, six weeks later, you've got to go back to the hospital. And you're supposed to feel exactly the same as what you did when you were pregnant, but you don't. You go back, and you feel SLIM and you feel abused that anybody wants to look at you. All of a sudden you feel like a woman again instead of a pregnant woman."

In the absence of any alternative coping mechanisms, the sexual nature of the encounter inevitably predominated: "So you feel awfully undignified lying there with your legs open and them taking wee SMEARS off you, and

putting their HAND inside you and things like that. You really feel, oh! Ken." (Upset tone, as if overcome by self-consciousness.)

The situation was exacerbated by the embarrassing discrepancy Anna perceived between her identity and her body image. She believed she was a sexual being, but she thought she looked unattractive when naked: "And of course, you dinna feel very nice. You're all stretch marks. You've got extra weight on still. You've maybe still got a flabby stomach and you feel - you know, if you were Racquel Welch lying there, ken, and they're having a look at you, you'd say, 'Oh well, I've got nothing to bother about because I ken I look alright.' But you DINNA look alright. You feel a mess. You feel a mess down there still aswell, you know. And I just didna like it. I was used to it when I went before, but not at that, I didna like it."

Anna clearly perceived the doctor as a man who was judging her body. Sattler (46) has said, "When a person is an object for the perception of another, he experiences himself as judged. This judgement has two aspects: (a) the judgement the other makes can be positive, in which case the experiencer can feel pride; and (b) the judgement can be negative, in which case the person can experience embarrassment and shame. Embarrassment refers to the fact that the experiencer, as a "voice of the mass," makes the judgement for the mass, for the other; and that no explicit negative judgement is required for embarrassment to appear. Embarrassment, therefore, is the possibility of a negative judgement in a situation in which one finds oneself an object of the perception of another." As Anna had developed no mechanisms to enable her to deal with the examination or the doctor outside the terms of the baby, she had no alternative but to feel judged. However, if past coping mechanisms emphasized aspects other than the baby the woman was much less likely to feel embarrassed by her post-natal

examination, as she could go on using the same mechanisms. Kathleen and Sheena gave examples of this. Both had been a little embarrassed by their internal examination at the Booking Clinic but both immediately resorted to coping mechanisms which focused on the doctors and the examination. Sheena stressed the professional nature of their role ("it's just their job") whilst Kathleen emphasized the fact that the doctor was "nice." She also relied on her positive image of the test (her mother had advised her to have a cancer smear after she married because, "It is - well, it IS really good.") Both girls developed these mechanisms during their ante-natal period and were therefore able to use them to avoid embarrassment during their post-natal examination. Sheena said, "Well, I knew that I just had to go and get it done, anyway. And I never really bothered. I was just glad to see that everything's alright. Och, you know that it's really their job, and I mean, it's really silly getting embarrassed because it's got to get done anyway. And if THEY'RE not getting embarrassed, why should YOU get embarrassed?" Kathleen picked out two important stage transitions on her way to unembarrassment: the breaking of her waters and the delivery. She felt unconcerned as to "what happened" to her after her waters had been broken because it was a male doctor who had done this - "And after that you never bother WHAT happens to you ... because the doctor breaks your water that way, the same way, sort of, as at the post-natal Clinic." And as for the birth, "You canna go any further!" The birth was commonly regarded as the ultimate in self-revelation; once it had been endured everything else of this nature appeared insignificant and nothing seemed embarrassing.

Kathleen also found justification for her lack of embarrassment in the behaviour of other women: "You FORGET so - it's just forgotten and that's it. And I suppose nobody would ever think you went through that. I mean,

you look at people who have had a bairn, and you think, my goodness, they've had to go through all that too, you know. And THEY never bother about it either. You see them, and you think, oh, THAT'S all forgotten, so YOU can forget about it, sort of thing."

The set of coping mechanisms the women chose depended partly on their images of the foetus, the hospital and the doctor. For example, Anna was able to use baby-centred mechanisms because she saw her foetus very much as a baby. It followed that Jean, who was never able to see her foetus as a baby, used no baby-centred mechanisms. Instead, all her mechanisms focused on the doctors. ("It's just their job ... they've seen a thousand women like me ... the doctor was nice enough, he didn't MAKE you feel embarrassed ... they're not really actually seeing anything.")

Women like Jean defined the hospital and doctors very much in clinical terms (47). Their mechanisms hinged on the belief that the doctors did not see them as sexual beings. The need to cling on to this belief could lead to rather bizzarre logic, as Kathleen showed: "Actually, I had the 'Sun' one day, and one of the doctors was there, and he's sitting looking at it. And he opens the page, and he goes, 'Ummm !', like this, you see. And one of the other doctors, he shows him this photo, and the two of them had a wee giggle about it, the nude woman in it. And you thought, how could they EVER, you know, think about it? It just shows how nothing matters to THEM, but, I mean, they can get pleasure out of seeing a woman naked in a magazine. You know, (giggles), posing. It seems funny, you know. They see patients every day like that. Well, not the same WAY, you know. But it gives them a wee thrill for to see it in a magazine. (laughs) I thought, my goodness, and I had a wee laugh to myself. He was a nice doctor, he was a right laugh. And I thought, what a nutter! So I mean, it just shows you, they don't have anything, you know. It's COMPLETELY DIFFERENT. A patient's

their business. I mean, they can still enjoy it some other way. You know - they wouldna - So I mean, seeing that, I thought, gosh, it's nothing to them. Really, it ISNA anything to them. They never think twice about it. I don't suppose." The important point here is, "It's completely different."

Kathleen based her argument upon her belief that the doctors differentiate between patients and nudes, but she sounded increasingly as if she was trying to convince herself of this.

But a few women found the whole situation so acutely embarrassing that they were unable to make use of any coping mechanisms. Perhaps the reasons behind their intense embarrassment lay in their background and attitude towards sex. It is perhaps significant that the two women who reacted in this way (Maggie, and to a lesser degree, Gina) spontaneously told me something of their uneasiness about sexual matters (48). For example, we have already seen how Maggie was embarrassed at announcing that she was pregnant because she felt she had not been married long enough. It may also be significant that she was far more preoccupied with cleanliness than any of the others. Gina's family were Italian in origin, and she had apparently never been able to discuss sexual matters with her parents. She was consequently extremely embarrassed at telling them of her pregnancy. She was also embarrassed at telling her brothers, "because they never think of their kid sister doing that." Alone of all the women, Gina told me that she preferred a young doctor to give her her internal examination because, "an older doctor could be my Dad." Thus there is some evidence to suggest that both girls saw pregnancy in sexual terms and found sexual matters embarrassing.

Because Maggie did not see her foetus as a baby (49), she was unable to resort to baby-centred mechanisms. Other people offered her a long list of coping mechanisms, but although she could accept some of them intellectually,

she was unable to believe in any sufficiently to act upon them. When he saw that she had returned home from the Booking Clinic in tears, her husband tried hard to provide her with a powerful coping mechanism : " My husband is always saying, 'You must remember', he says, 'that it's just like me', he says, 'when I'm doing my trade. It's just the same as them - you know, YOU'RE just the same to them.' 'I know', I says, 'But I just don't feel right.'" Although friends assured her that "when you have a baby you just leave your pride on the doorstep", Maggie was never able to come to more than a tentative acceptance of this. Therefore, after her visit to the Booking Clinic, all she could do was try and persuade herself that she would "get used to it" : " You know, they all said to me, 'You get used to it.' - Oh well, I think I will, through time I suppose. There's nothing else I CAN do ! I mean, I've got to go through it all."

Because she had failed to develop any viable ways of coping with her embarrassment, she was again embarrassed by her ante-natal care at the hospital. (She was atypical in this.) She told me, " I just don't know WHAT to say to them. I think I feel that embarrassed ... When you're lying on that bed and that ... I don't feel so bad as what I did at first, but - I feel O.K., you know, when they're taking my blood pressure and everything like that. But when it comes to feeling about - when you lift up your dress and that for them to feel about your stomach and that, that's when I get embarrassed." In the absence of coping mechanisms, she was left to define the encounter as a sexual one (note that she called the couch a bed). And she was reduced to the following behaviour in an elementary attempt to shut out what was happening : " I shut my eyes or look at the ceiling. I just look up like that, or close my eyes, and try not to think about it."

Like all the other women, she was unembarrassed by the birth, but significantly

she coped with it by focusing on the pain. Therefore, once the contractions had stopped, she was left without any way of coping, with the result that she found the stitching extremely embarrassing : " This was the worst part, you know. They put your legs up in stirrups. And the doctor sits at the bottom of the bed, and sits and stitches you up ! And I thought it was terrible ! And I'm saying to the nurse, 'Oh, can he no hurry up ? I've got pins-and-needles in my legs !' ... I think that was the most embarrassing part. I think it was because it was all over and done with that I found it embarrassing. But when I was going through the pain, I didn't find anything embarrassing."

Maggie was never able to develop a professional persona for the doctor. Therefore a basic cause of her embarrassment was her image of the doctor as a man. Similarly, Gina had difficulty in sustaining her image of the doctor as a detached professional. Throughout her pregnancy and delivery, Gina never mentioned a mechanism which centred on the doctor. Perhaps this explained why, in contrast to Kathleen, her image of the professional doctor shattered after she witnessed the following scene : " The day when I got that internal, you know, I was as embarrassed as hell, and I didn't know where to look ... He was quite a young doctor, say a man about in his thirties, and he was capering with one of the patients in the corridor. And he opened the first two buttons of her house-coat, ken, and he was kidding her on, ken, and giving her the eye and everything. And then I was to go in for my internal afterwards, you see. I thought, my God, he's a man ! (laughter) Before he had just been a doctor ! It suddenly struck me after that he was a man. He hadna been a man before that - just a doctor. Just an 'it'." This episode marked a stage transition for Gina. During her stay in hospital, she had felt a little more embarrassed day by day, until her embarrassment finally overcame her during this last internal.

It was inevitable that both these women would find the post-natal examination embarrassing. Maggie was still seeing it as a sexual encounter :

" I think it's because you've got to sort of lie upon a table and open your legs - you know, it IS embarrassing. I don't know. It's a thing I always thought would be embarrassing, and you still sort of FIND it embarrassing."

By claiming that she only returned to her "normal self" after the delivery, she retrospectively defined labour as an abnormal process. The inferences here were two-fold. Firstly, if labour were an abnormal process, ordinary rules regarding embarrassment could not apply - in which case her lack of embarrassment was explained and justified. And secondly, if she lost her embarrassment during an abnormal process, she was saying that it was normal to be embarrassed. She based her perception of labour as abnormal on the pain which caused a change in her feelings : " I mean, at the time, you ARE going through that much pain that you don't find it embarrassing, but once it's all over and done with, you're back to your normal self, and your own feelings again, where you find it embarrassing. You pick up your modesty because you're back to your own feelings. I mean, when you're in labour, your feelings are all different, you know, because of what you've been through. But when you're home you're just back to your normal self. So I mean, you canna just change your feelings, how you feel about things, you know." She described her feelings during labour as follows : " I don't think you could really care what happened to you, as long as it was all over and done with. You couldna really care what they were doing with you at the time ! Because you think to yourself, well, they're only trying to do it to help you. To help the baby come, you know." Central to her attitude towards embarrassment was her conviction that "you canna just change your feelings". This was another way of saying that she found it impossible to

erect any coping mechanisms.

As well as redefining the birth as an abnormal process, Maggie redefined her ante-natal care as unembarrassing : " They were O.K. I mean, all you did was go in - it wasn't anything like the first one. (giggle) You just went in, and they just felt about your stomach to see if the baby was O.K. and how it was coming along and that ... You never really got examined. It was only your stomach got pressed. So it didn't really matter." Perhaps in relation to the birth Maggie now saw her ante-natal care as a much less threatening ordeal than it had seemed at the time. Or perhaps her redefinition of labour as abnormal extended throughout the rest of the process. If she came to see pregnancy as an abnormal state, then it followed that the normal definitions and rules of behaviour did not apply. In that case the medical examinations could not be seen as sexual encounters, with the result that she was forced to redefine them and claim that they were not embarrassing.

In conclusion, these two groups of women, i.e. those who were embarrassed and those who were not, seemed to see the process of pregnancy in different ways. Those who were embarrassed postpartum seemed to see their experience rather as a cycle. That is, after bearing their baby, they reverted to the identity they believed they had had before they were pregnant. Anna illustrated this when she failed to relax during her post-natal examination. Her doctor, who had also been present at her delivery, slapped her legs and told her, " You've reverted back to your old self." " I says, 'Aye !' (whimperingly)." Someone like Kathleen could argue that as the birth involved the ultimate in self-revelation, she need never feel embarrassed again. But this would have seemed invalid to Anna, as she recognized two different identities during the process (for example, " All of a sudden you feel like a woman again, instead of a pregnant woman." (50)).

Those who were unembarrassed saw the process as more linear - a straight line of maturation. Kathleen provided an example of this when she redefined a past episode, which had seemed very embarrassing at the time, in the light of her present experience : " I was worse, actually, when I went in for my back. Because I was only fifteen then, and I think that's about the worst time. And I mean, it was nothing NEARLY like the birth, you know. They pulled about with my legs and things like that. But I mean, it was nothing. And it was all nurses, more or less, then. But er (giggles) when you thought about that, you know. And you think NOW, and you think, what a silly wee lassie I must have been then. You know, they see it every day. THAT'S what you keep saying to yourself. It's O.K., they've seen hundreds, you know." Perhaps one aspect of maturation is an increased ability to create and act upon coping mechanisms. Brenda also felt that she had developed. After listening to women in her ward discussing sexual subjects, she felt able to mention intimate matters to her doctor and talk much more freely about sex with her mother. In Goffman's terms (51), these are the women who have "proved worthy" at a later time, and are now able to present "a sustainable and coherent self".

Conclusion

There are three main encounters during pregnancy which primiparae either find or expect to find embarrassing. These are the visit to the Booking Clinic, the birth and the post-natal examination. Of these, the Booking Clinic is the most alarmingly embarrassing, mainly because it is the first time that many women receive a vaginal examination. During this examination the women were usually unable to redefine their images of themselves and of their doctors quickly enough to maintain their poise. Contrary to their expectations, none of them found the birth embarrassing. Whether or

not they were embarrassed by their post-natal examination depended upon the nature of the coping mechanisms they had used previously.

There are several reasons why the women felt embarrassed. At certain stages the identity they wanted to project (a sexual being) was incompatible with the one the medical situation demanded (a non-sexual being). Then, in the early stages their uncertainty about procedure led them to mishandle their equipment, especially their clothing. And, if the doctor was young, as so many of them were, many women had difficulty in sustaining a belief in his identity as a detached professional. Therefore, given the posture and self-revelation necessary in a vaginal examination, and their often hazy ideas as to the relevance of the examination, several women found it hard to sustain a definition of the encounter as a purely medical one.

My empirical data would seem to substantiate the theoretical work of Gross and Stone (3) and Goffman (2) : that is, to flow smoothly, interaction requires that identities be valid, that participants be poised and that they maintain confidence in one another's identity and poise. However, perhaps my study adds a footnote about poise. Goffman (52) has said that : " A person may be out of face when he participates in a contact with others without having ready a line of the kind participants in such situations are expected to take." Following on from this, my work emphasises that it can take some actors a long time to redefine the situation and develop such a line. Indeed, some women may find themselves utterly incapable of ever doing this. Finally, my work shows the importance of the nature of the coping mechanisms actors use when they undergo a transition. The mechanisms which prove successful during the early stages may well prove inadequate at a later date when the situation has changed.

Introduction

The management of pain was a central problem. The interview transcripts reveal just how much energy the women spent on coming to terms with pain throughout their pregnancy. The explanation for this was simple : only if they could cope with the pain of labour could they maintain their self-control and avoid the embarrassing revelation of another, less desirable self (1).

This chapter begins with a brief look at their different images of birth. Their predominant image was that birth would be painful. Next, the women's attitudes to pain are discussed, and this is followed by a description of the main mechanisms they used during pregnancy in an attempt to cope with the prospect of a painful labour. The mechanisms they used during labour itself are then considered, and the chapter ends with a short account of the range of attitudes they held towards pain and birth once they had safely come through the transition.

Images of Birth

All cultures place some importance on birth, but all cultures do not share the same images of birth (2). This section describes some of the images my respondents had of birth.

Societies vary as to the amount of secrecy with which they surround birth. Some have a frank approach : birth is seen as a social event which is openly acknowledged by the community, and the children are well-informed about childbirth. My women did not find this. Because they saw birth as uncertain and mysterious, they often felt afraid of it. Anna told me, " You're feared of anything that you don't know about, that you've no experienced. Well, you're feared the first night you get married. You're just as feared, having a baby - in fact, you're going to be worse. " Far from being an open, social event, the women expected birth to be " an awful lonely thing, with all those strangers and all that pain. " Popular myths or partially true accounts heightened this image : several women were told that they would be left alone for long periods during their

labour, or that staff would forbid them to bear down when they wanted to. A few women saw birth in terms of the supernatural. Expressed positively, this meant that they saw birth as a miracle (" You know, I began to really think - it's a miracle : How can that happen to me, you know ! ") More negatively, birth could be seen as a time when " you never know what can go wrong ". Thus Sue worried that she might lose her baby, and Jean voiced her fear of " being left to die ".

Central to the Hebrew-Christian tradition is the belief that birth is dirty and defiling (3). Perhaps this explains why some women found the prospect of birth distasteful. For example, Brenda was disgusted on discovering that the baby would be " messy " at birth, whilst Joan significantly equated the film of childbirth with photographs of dissected animals in a veterinary department. It was the women's position during labour which concerned Judith and Elspeth. As Elspeth said, " I suppose it's a wonderful thing, but you're pretty undignified-looking for most of the way through it ! (laughs) I mean to say. Apart from the fact that you're big and fat and ugly. And you've just about nothing on you. Eeghh ! (distastefully) ".

It was more unusual to see birth as an achievement. Ruth told me, " I'm really looking forward to HAVING the baby, because I think it must be a lovely feeling to waken up and actually see what you've produced. This is something I'm looking forward to, you know, coming round and saying, have I actually brought this into the world ? ".

Nearly all the women defined birth as inevitable and themselves as helpless in the face of this relentless process (as Elspeth said, " It's got to come that way ! "). They went on to use this image in order to persuade themselves that it was pointless to worry about the labour, as it would happen anyway.

There seemed to be some ambivalence as to whether birth was an illness or a natural process. Julie definitely saw it as natural. Discussing her fear of hospitals she said, " But it isn't the same kind of thing, I don't suppose, going to have a baby, as going in for any other reason, you know.

Because I KNOW - (dramatic pause) that I'm going to come out ! (laughs)
Or else ! But, you know it's just a natural thing. " But other girls saw labour as an illness and birth as an operation. On the whole, they tended to be the women who had not been to the Relaxation Classes and knew little about what went on during labour. For instance, when Sheena talked about the birth in her last interview, her comments showed that she had initially thought of birth in these terms : " And then I thought, when you get your waters broken, you get put on a stretcher, and away up the stairs. And after you get your waters broken (giggles) you get told, 'That's you', and you stand up and walk away up stairs ... I always thought when you went into labour you'd be lying right out, and WE were sitting reading magazines ! (laughs) I just always thought that once you went into labour that'd be you and you'd be lying there. That's the picture I got, but it was nothing like that ... I always thought of DOCTORS and nurses, and it wasn't like that at all. It was just the two nurses."

But all the women agreed that, most importantly, the birth spelt pain (4). Sophie said, " I think the outstanding thing that you pick up from quite an early age is the amount of pain you've got to go through. I've found that this is something that always seems to be stressed. Particularly on the television, say like a film or a play, you always seem to see the woman lying there in agony. And, of course, this is impressed INTO you that, oh, if you're going to have babies you're going to have to suffer pain at the end of it all. "

All encounters involve a risk to the participants' identity (5). To many of these women, birth entailed an extreme form of risk-taking. To them it became almost an endurance test : they believed that they must maintain expressive control whatever the pain. Judith said, " When time goes on you sort of think about it a bit more, and you say to yourself, ' Oh ! I hope I don't make a fool of myself ! ' That's what bothers me more, I think ; I hope I can keep myself in control." Sophie was saying the same thing when she told me that she did not want to "lose face that way". She felt that screaming and shouting would destroy the image, or "face", she fostered of herself as a capable and dignified woman, and she knew that

once her labour was over she would feel embarrassed when she remembered that this other, less desirable self had intruded (6). Those girls who did manage to maintain expressive control during labour felt very proud of themselves and believed that they deserved praise.

Their belief that there was a right and a wrong way to behave during labour encouraged the women to work out their perceptions of pain. In this way some of them came to see it as a necessary and positive part of the overall rite de passage. All of them saw the need to formulate coping mechanisms for pain which they hoped would enable them not to "let themselves go".

Perceptions of Pain

Most women told me that they were frightened of pain ; the popular refrain was, "I'm a coward where pain's concerned". Christine said, "You know, even the thought of it, I used to say, when I knew I was having a baby, 'I wish they could just cut me open and take it out of me.' (laughs) I'm a coward for pain. I hate pain." (7).

All of them were unsure what the pain would be like, how intense it would be, and whether or not they would be able to bear it ; but, because of the premise that a novice must not be frightened, they found it difficult to get reliable information from their friends. Thus uncertainty fed their anxiety that it might be impossible to maintain control during labour, and made it difficult for them to prepare themselves for pain.

Unlike most women, Maggie was able to give pain a positive function :

"Really, I suppose you've got to experience it all, you know - for it to BE yours . You couldn't sort of go through - you know these people that have injections so that they can't feel any pain ? I don't feel as if they've experienced anything. Whereas you feel that you've achieved it yourself if you went through the pain of having it. You feel more - em, sure it's yours, you know " (8). In a rather similar vein, Judith told me, "You sort of realise that it's not going to be easy, but anything worthwhile doesn't come easy, does it ? ". In so far as both were suggesting

that they had to suffer to have the baby, they were seeing pain as an integral and necessary part of ^{the} rite de passage.

How the Women Coped with the Prospect of Pain when they were Pregnant.

Because they were apprehensive about the severity of the pain and their ability to maintain control during labour, the women worked out coping mechanisms which they hoped would enable them to keep their poise during this crucial time. Gross and Stone (9) have explained why such preparation is necessary: "... that which embarrasses incapacitates role performance.... the conditions for role performance (are) identity, poise and sustained confidence in one another. When these become disturbed and discredited role performance cannot continue. Consequently provisions for the avoidance or prevention of embarrassment will be part of every persisting social relationship."

It seems that women have always feared that labour will be painful. Ford found that rituals and customs believed to avoid painful delivery had developed in thirty five of the thirty eight cultures he studied (10). Pre-industrial societies abounded with different ways of coping with painful labour (11). Several societies believed that certain stones had a beneficial effect. This belief goes back to the ancients (for instance, jasper was thought to be effective in Graeco-Egyptian times). The eagle stone has been particularly popular throughout the ages (12). The ancients thought that iron oxide checked bleeding and therefore helped conception and protected against miscarriage. Around the sixth century the idea developed that the eagle stone attracted or pulled on a new-born child. Consequently the stone was bound to the woman's arm during pregnancy to prevent the loss of the foetus, and then fastened onto her hip during labour to ensure that she would give birth without pain. In Britain this belief persisted into the eighteenth and nineteenth centuries.

The use of girdles goes back to the Ancient Britons. They were tied

round the waist of the woman as she lay in labour, and the ceremony of binding them was accompanied by gestures and incantations. Brand, writing in the early part of this century, said that girdles were "till lately" carefully preserved by many Highland families (13).

In medieval England doors and cupboards were often left open to encourage the child to emerge (11). Word charms were also popular throughout Western Europe during this period (14). Religious beliefs have also formed the basis for coping mechanisms. Thomas describes how in England during the Middle Ages Masses were said for women in labour, and prayers given up to the saints, particularly the Virgin Mary and St. Margaret. However, as Bibring (15) has pointed out, the current emphasis on the rational and scientific approach has prevented women from finding solace in superstition. Therefore, in the absence of any societal mechanisms, women today are left to work out their own ways of coping with labour. That they found birth a daunting prospect is indicated by the joking references they made about it. For example, a favourite was, "I'm not going through with it/ You don't have much choice." The mechanisms used by the women to cope with pain and its ramifications can be summarized as follows.

Because they believed that certain types of behaviour reduced the amount of pain during labour, some women took care to observe certain behavioural rules during their pregnancy. For instance, a few women tried to eat sparingly so that the baby would be small and therefore, they believed, less painful to deliver. Others concentrated on working out the type and intensity of contractions, and assessing their ability to cope with them, whilst several reminded themselves that they were merely ones of hundreds of women who had "gone through it." Other mechanisms were to define the birth as "normal" and therefore safe, and to look to the husband's presence for support during labour. Throughout their pregnancy the girls were assailed with alarming tales of nasty labours, which they coped with by developing various rationalizations for disbelieving

them. These will be outlined in greater detail below. Many women reassured themselves that modern scientific techniques would ensure them a relatively painless birth, whilst those women who were keen to become mothers told themselves that producing their baby would make everything worthwhile. Girls like Pat were openly fatalistic: "What's the good of worrying about it? I mean, when it'll come, it'll come. What's worry'll no go past you, that's my motto." And finally, there were the women who repressed all thoughts of birth.

We can see several of these mechanisms operating for Sue during her first interview: "The only thing that's worrying me is going through labour. I mean, even THAT, I mean, I don't think there's anything to it, I mean, really. I mean - if everybody goes through it. You see people with two kids, three kids, even six kids, and you know, I've often wondered, I've often SAID this to myself, I says, it canna be all that bad. If it was that bad and you went through it once, you'd never go through it again. If it was that bad to me, I'd make a point of not going through it again. I really would. So you say there canna be much to it.... I think it'll be worth while. I think of other people, you know. I say I'm not the only one. There could be HUNDREDS having their babies the same time as me. I think it canna be that bad as what a lot of people make out. A lot of people have said to me, 'I've had a right bad time.' And I've met people who would say, 'I never felt a thing. I'd go through it in a minute.' And you hear ONE story and another. What really makes me feel a lot easier about it is that with that smear test, you know, everybody saying how bad it was and how you'd be in pain and you wouldn't be able to walk for hours, I mean, it did bother me and I was worried stiff. But when people now say things, 'Oh, I've been in agony, you know, having it,' I just think of the opposite, after that smear. Because I didn't feel it. I mean, I know I go through something, but I won't be that alarmed that I'd sort of panic."

Here Sue began by using others as positive role models ("you see people with two kids, three kids, even six kids"); then she briefly used a baby

mechanism to reassure herself of the value of going through the pain ("I think it'll be worth it"),and then derived comfort from the image of herself as merely one of many going through an ordinary process. She concluded by persuading herself that she did not need to believe the frightening tales that she had heard because her informants had been proved wrong in the past.

This was just one of the many ways by which the women justified their disbelief of these tales. The favourite was the belief that 'everybody's different' which has already been mentioned in Chapter Four. The rationale was as follows: if everybody is different,it is irrelevant that somebody else has had a difficult labour,as you will probably not be like her. This useful belief was reinforced by the scientific belief (learnt from books and the Classes) that each person has a different pain threshold,and therefore what is painful to one is not necessarily painful to another.

Alarming tales could also be neutralized if special circumstances could be found to explain them away. For instance,Anna explained away her mother's account of her difficult labour by claiming that everybody delivering twins is bound to have a difficult labour.

Sophie was sure that women exaggerated: "There's something about people. Human nature in particular,they seem to LOVE going on about pain and different ailments. And I think they tend to exaggerate it. Half these things. If you go into hospital,you know,no matter what you've been in hospital for,childbirth or whatever,if you can elaborate it a wee bit and you're saying to your audience,'Oh,it was dreadful. All the PAIN, and all those injections!' I think a lot of people feel a wee bit disappointed if they go in and have an operation and it's not half as bad as what they thought it was. People EXPECT them to have suffered great things,and the more sympathy you can get the better it is. The better you feel for it,you know."

Similarly,Elspeth believed that some women redefined the past and presented the birth as being worse than it really had been: "Then my own

girlfriend, she had Kirsty just over three years ago, and when I saw her a fortnight ago she was on about the pain and everything like that, all the things that had happened to her. And I said, 'I don't want to know.' Because I remember when I went in to see her the day after she'd had her baby, she says, 'Oh', she says, 'It's nothing. I'd go through it again.'

Three years later she's saying something different, you know!"

Other girls went further and discredited the teller. Pat and Jean felt justified in dismissing tales of their sisters' painful labours because "she's always been sort of scared," and "if she had a headache she used to grete her eyes out." And finally, if all else failed, they could, like Shiela, always refuse to listen: "The girl upstairs, she had a wee girl six weeks ago, and I met her down the stair on Saturday for the first time. And, 'Oh,' she says, 'I had a section. It was terrible!' I says, 'I don't want to hear about it.' I think it's silly when you're expecting yourself, people saying things like that."

Perhaps because they worked on the assumption, 'better the devil you know than the devil you don't,' many women spent a lot of time trying to work out the type and intensity of their contractions and assessing their ability to cope with them. Several women wondered if they would be like menstrual pains. Helen said, "I try to imagine what these contractions'll be like, because I know it'll be PAIN, like. I just try to imagine just how much. THAT I think about, you know. I know that when I was very young, just started periods, you know, I used to have terrible pain, really shooting pain. I used to have to, wherever I was, just DROP down on the chair, or sometimes on the floor, it was so bad. And I often imagine if it'll be that type of pain I have, or what kind it'll be." In this way she tried to convince herself that she would be able to cope with her contractions.

Ruth used the pain she suffered with her appendicitis in a similar way: "I wonder sometimes will I have a lot of pain. Or will I just be lucky and have little pain. But I don't think I can have very much more than I've already had. Well, one woman told me, she said appendix pain's far

sorer than any labour pain. So I thought to myself,well then,I can. If I can stand that,I can stand anything."

Ruth also seemed to feel that if she could work out some known quantities in the expanse of unknowns she could cope more easily with the birth. With the help of the teaching at the Relaxation Classes she was able to construct islands of certainty in a sea of uncertainty: "And they tell you also what they're going to do. Which to me - oh,you're prepared for it! It's not something that's just going to happen out of the blue - it's not going to happen and you're going to scream and say,'I didn't know that was going to happen!' I feel now I know what I'm going into. They also let us have a breathe in on the gas and air. Well,I had had it before, because I had it when I had my appendix out,you see,so I've had the gas and air,and so I know what it feels like.... And then the first injection they give us is heroin.... and then the next injection's pethodine. Well,pethodine's quite a nice injection,actually. It relaxes you. You get it as a pre-med if you've ever had an operation. And so I'm not worried about that either,because I've had quite a lot in my time.... And she explained everything that's going to happen to us before it, like getting shaved,you know. One girl looked at her. She said,'What? Down there?' you know. And she said,'Oh,that would hurt.' I said,'No, it doesn't,actually.' Because I've had it done when I had my appendix out. They do it then " (16).

The present scientific approach at least enables women to turn to modern medicine. Sophie,for instance,relied very heavily upon her belief in the rational approach and the efficacy of science. She began by stating her belief that "everybody's got their own what you'd call pain threshold. Some people can stand more pain than others,and I think as long as you're going into it with an open mind,you've got to reckon that,O.K.,you're going to suffer - if you CAN,the best thing is obviously to relax. Common sense'll tell you that anyway. And,O.K.,this is one of the things they stress at the Relaxation Class (17); you must relax,and if you do it'll help you through the contractions. I suppose the thing is,if you

were able to concentrate completely on your breathing and various exercises, well, if you're in the right frame of mind I can see how it definitely would help." She went on to express her faith in drugs: "I'm led to believe that they'll give you various pain-killers and gas and sedatives and such things so that, er O.K., I'm quite happy just to lie there and suffer and get on with it." As part of her rational approach Sophie tried to work out ways of coping with her pain in advance: "I've a pretty good idea of what's in front of me, so I figure if you can sort of bear with the pain, and sort of lie there, I find that concentrating on it until it goes away seems to help somehow. Rather than fighting against it and moaning and wriggling about." She drew on past experience at the dentist to support her belief: "It's the same at the dentist. I find that if you're trying to let your mind wander and not think of this nasty man with his big long needle coming to stick it into your gum, of course, you're usually brought back to earth with an unpleasant jerk as he sticks the needle into your gum. And I find it easier if you're lying there and you're thinking, 'Oh, here's the needle now. It's going to go in - there, it's going in and he's injecting the stuff into you - there, that's the needle out again.' Rather than trying to take your mind away. I don't like my mind taken away from the pain. I'd rather just stay with it."

Her rational approach was also paramount when she added, "I just think about it in very sort of practical terms, really. I know all about the different stages and how the labour starts off, and all the various signs to look for. And I think about it purely on that sort of basis I think as long as you're going into it with the correct frame of mind, you know, sort of think about it from time to time, you know, what's to be expected, and that's it."

Like many of the others, Sophie evinced a vague faith in modern medicine not to let her suffer very much: "I think especially these days, I don't think you're really expected to suffer pain or to have babies naturally

as perhaps was the case ten, twenty years ago. It wasn't really the case, I believe, in those days for them to induce a birth. They'd just leave you to go over your date by a couple of weeks or whatever, and it was just a case of you were in hospital and they left you there on your own to get on with this natural process. You just lay there and suffered. Now, I believe, they don't have you suffering any more than is necessary. They're not going to have you lying in agony trying to produce a child if they could probably skip all these hours of agony and give you - er, you know perhaps even a Caesarean or - you know, have a forceps delivery or even give you one of these epidurals or what have you."

Sophie's mechanisms for coping with pain were mostly of this kind. Only once did she mention a baby mechanism, and then only in a half-hearted way ("And they do say at the end of it it's all worth it. Once you hold the little - treasure in your arms, you know, it's all worth it.") It is interesting to speculate whether such a bias towards the scientific and rational mechanisms and away from the baby-centred ones is typical of women who, in the terms of my earlier analysis, are not strongly 'maternal' (18).

If all mechanisms failed as a last resort the women could always repress the birth. Jean did this: "I try to keep it at the back of my mind until the time comes and I'll face it then. As they say, cross your bridges when you come to them. Because if I sit here now and say, 'Oh, I'm going to be in a right lot of pain,' I'll just drive myself nuts, so I just forget about it and just busy myself with other things, thinking about when he's born. I miss that bit out entirely. I'm just going from here to there. Because I say, right, I'll think about this, and I'm looking to see all the things I need for him. And then the next thing I think about is what I'm going to do with him when he's born. But I never think about the birth. No unless it comes up and I just shove it to the back of my mind because I dinna want to think about it even. Because there's nothing I can do about it. I mean, I'm going to have to go through it anyway, so that's that."

Coming to terms with pain occupied much of the women's energy during pregnancy. In delineating the different coping mechanisms they used, I may have presented a rather static account. However, their attitudes towards pain did change with time, but not in any very straightforward way. Some women grew less afraid as they drew nearer birth because the Relaxation Classes, in telling them what to expect and how to behave, had given them confidence (19). Those who repressed the birth often became more afraid as the nine months ended and the labour became more of a reality.

Coping Mechanisms During Labour

Surprising though it may seem to us, some societies try to make women suffer during childbirth. Ford describes how the Thonga midwives knead the expectant woman's body with their hands and sometimes their feet in an attempt to ensure that the afterbirth and the child are expelled together (10). Other societies, including our own, make every effort to alleviate pain. Most have prescribed special techniques to use if delivery becomes especially severe. Ford cites societies where husbands perform a ritual to speed the child's safe delivery. Often the cause of a difficult birth is considered to be some violation of the mores - perhaps the woman has committed adultery and not confessed it, and so she is urged to reveal her lover's name to save herself much pain and suffering. Alternatively, it might be interpreted as the malevolent action of spirits, in which case the spirits are either given battle or persuaded to desist through prayers and sacrifices.

Nowadays not only are there no universally accepted theories of cause and effect as to why some women have bad labours, but as religion and superstition have largely become bereft of meaning, women tend to rely heavily on science to help them cope with their pain. The main coping mechanisms the women depended on were drugs, the breathing exercises and the old-fashioned remedy of gripping on to something. Some women also concentrated on the baby so hard that their pain was dulled. Different women used these methods with varying degrees of success. This section begins with a short account of Anna's labour. She managed to use the range of mechanisms very success-

fully (20) : " When my water got broken,I think it was twenty to eleven. I didna have my first jag until nearly tea-time. So,I mean,I done quite well on my own. I mean,it was just like a period pain. Well,I've had some bad period pains,so I knew all about pain ... Well,after an hour or so of being induced,I took the pains every two minutes. But they were gradual - they werena very painful. But I started my breathing right away. I was being a model patient,you see ! I was showing them all that I'd been to my Antenatal ! (laughter) ... Everybody's got a different pain peak. You know what I mean ? You can only stand so much pain. Well,of course, I'd been used to having really bad period pains,and I just took them - no in my stride,because they're painful,I mean,but ... I did my breathing and I held on to the bed. And I held on to my husband's hand ... I just think that you shouldna worry so much about the birth,because it's really - I dare say without drugs it would be bad. But the drugs that they've got nowadays,they're so - I mean,one jag and I felt nothing. Well,I'm no saying that I felt NOTHING,but I could cope with any pain that came my way, you know. And then eventually,when it got much nearer the time,I got another injection and that was me. Two jags and I had the baby no bother... But I mean,that's what I was feared of. I was feared in case I made a fool of myself. You know,startred SCREAMING and saying things I didna mean. Saying, ' Oh,what a stupid doctor,you dinna ken nothing.' But I was alright. I was quite proud of myself,actually. "

Sophie's experience was less happy. During her pregnancy she had invested all her faith in the power of modern medicine (21),but her attitude changed after she had given birth to Jane (20) : " I went in at half past eight on the Tuesday morning ... Of course at THAT time I was just sort of panic-stricken,you know. I felt faint,but they just put it down to the heat and the way I was lying,but I knew it was just terror! Sheer stark terror at the thought of what was in front ... So he started the birth, and it wasn't too bad at all. It must only have been ten or fifteen minutes,so I thought to myself,oh,it's not too bad at all. So they wheeled me through to what they called the first stage labour room. Of course,that part of the City's very modern. Very bright. And they put me

to bed, and I thought, ' Oh, this isn't too bad ', and this young lady fitted me up with a drip. They sort of stick a needle on to your wrist and fit you up with this thing. Well, I hadn't fancied that EITHER, being a bit squeamish with needles, but it wasn't TOO bad, so I thought, oh, GREAT, you know. Well, to me, that was going to be the worst part. Over and done with. Oh oh! Little did I know ! ... And this nurse says, ' Would you like some magazines ?' I said ' Yes, please.' and they brought me through a pile of nice, new magazines. And this other lady brought me a cup of COFFEE, and so it was rather nice. And I got a small PAIN, and I thought, ' OH! ' (in surprise) You know, just something like a period pain. So I said to the sister, ' I've just had a small pain. Is that quite normal?' , ' Oh, yes', she says, ' That's pretty good ', she says. ' That's what we call instant labour.' So I thought hmm. I thought it would have taken much longer, you know ... But however, I thought, well, that wasn't TOO bad, you know, if it keeps going like this. So I started to have a read of my magazines, and two or three minutes later ANOTHER pain came, which was even STRONGER. So at that I threw aside the magazines (laughter) and started practising my breathing. I thought this is a wee bit strong - maybe that was just a FLUKE pain. And I thought, oh well, that was it over, you know. Back to the magazines and let's see what's happening. Again two minutes later another one - and THAT'S how it went on. And I must say I was completely unprepared for the speed at which the contractions came, and the intensity so early on in labour. "

Throughout her early stages Sophie tried to reassure herself that all was well. She coped with the pain by likening it to a menstrual pain (with which she was much more familiar and confident of her ability to bear); and dismissing the first strong pain as a fluke and therefore atypical. But once the contractions became more pronounced, she had to resort to other mechanisms : " Well, I'd been in the first stage of labour till about twelve. A couple of hours. And it was really one pain after another. And well, looking back, at THAT stage it wasn't TOO bad. It was BEARABLE, you know. I wasn't lying there shrieking away or anything. I was just lying there thinking well, at least we're getting somewhere. "

Her problems began once she was wheeled into the delivery room : " By that time they were really quite severe,and I felt easier lying on my side. But they kept wanting me on my back for this machine." It was at this point that Sophie lost confidence in the ability of drugs to ease her pain," Now at this stage I thought they were paying a wee bit too much attention to this machine and not bothering about me. I think,looking back,well you're just another human being giving birth,and you've got to suffer the pain, there's nothing really they can do for you. They gave me an injection just before the pains were getting bad,and I felt a bit dozy,but it didn't do anything to ease it. " Later she added," Honestly,I had the impression from other girls that when you were having a baby,you were so sedated and drugged that you either slept through the whole thing,or you hardly felt a thing. Well,whoever said THAT to me,they're LIARS. I just didn't find the injection helped at all. Somebody said that the injection is supposed to help the pain. Well --- maybe it DID. Maybe it's even WORSE!" At this stage Sophie realized that there are limits to the amount of drugs a woman in labour can have: "You know,for the baby's sake,and then they want your cooperation,especially when you get to the second stage,because of the bearing down."

She finally managed to cope by "keeping my wits about me." By this she meant relaxing and concentrating on the pain rather than fighting against it. She told me,"It's very hard to relax because the pain is such that it really grips you,and it's the hardest thing in the world to try and hold yourself still and to actually bear with the pain. And that's where I felt the relaxation and breathing exercises came in." However,Sophie found that if she "lost control for one minute" less effective coping mechanisms took over and she was "arching my back and looking for something to hang on to,as in the old-time movies,you know!" But despite her difficulties,like most of the other women Sophie largely managed to maintain her self-control. In fact,it seemed that the greatest threat to the maintenance of face came not from weakness over pain but,rather ironically,from inconsequential "blethering" brought about by the drugs. For example,Anna told me,"I went into the delivery room

and I'd seen this young doctor once before but I couldn't quite remember. And I was away with the drugs, like. And I remember saying, 'Who are you, anyway?' (laughs) Awful cheeky, like. And he laughed and he says, 'My name's Peter.' I says, 'Peter who?' He says, 'Peter Brown,' and I says, 'But who are you?' He says, 'I'm a practising doctor.' I says, 'A student, like?' He says, 'Yes.' I says, 'You're trying not to frighten me, eh?' He says, 'No, no, not like that,' but he was. He didna want me to know he was a student, you see, incase I got feared. I says, 'Are you going to deliver my bairn?' He says, 'If you'll LET me.' I says, 'Oh aye!' (grandly) As if he wasn't going to ANYWAY! And he kept saying to me, 'You're being very brave, you know.' And I'm saying, 'Oh, RUBBISH!' Oh, when I think of it now! Dr. Jones and sister are standing laughing because he was getting embarrassed. He was right SHY.... I was just blethering a load of rubbish. And he come round the next again day. Boy, was my face no red! (laughs) I couldna even look at him. And he come up to me and he says, 'Are you no talking any more?' I says, 'No!'"

Attitude to Pain after Birth

Newton has reviewed the literature on the relationship between what she calls pregnancy psychology and labour (22). She concludes that the relationship is a complex one. It is difficult to deduce any conclusive results from my small-scale study but my data would seem to support

Chertok: "the woman with a more accepting attitude towards her female biologic role and toward life in general appears to have a more emotionally controlled and comfortable labour" (23). That is, those women who were strongly 'maternal' felt they had an easy labour, whereas those who were less strongly 'maternal' felt that they suffered a great deal (18).

There were a variety of reactions to birth. There seemed to be an assumption that it was somehow preferable not to be induced (24); it was thought to be better to "go naturally." Induction seemed to hold connotations of abnormality and failure. On the other hand, inductions were welcomed because they at least solved the problem of deciding when to go into hospital - they eliminated the risk of the girls' making fools of

themselves. They meant that the women knew exactly when they were going into hospital and so there was no need for them to worry about the possibility of an emergency rush into hospital during the night. (Sophie, however, found the certainty of knowing when she was going to have her baby a nerve-racking piece of information in the way that the definiteness of a dental appointment is nerve-racking.) Elspeth welcomed her induction because she believed it would mean a shorter labour and therefore less pain - and because by that time she had become so desperate that she was reduced to feeling "just anything to get it over with."

As to the pain itself, all the women felt that it was "a pain you forget." Elspeth told me that as soon as her contractions stopped and her baby was born she forgot what the pain had been like. It was almost as if there was a biological safety mechanism at work erasing the memory of the pain. Maggie had forgotten almost everything: "You forget about everything. I mean, it doesn't seem as if I ever went through having a baby. I mean, she's THERE; but you never sort of think what you went through to have her. Until somebody asks you about it or talks about anything like that, you know. That's when you remember, but other than that you never THINK that you had her inside you."

Joan strongly resented the fact that women seemed to enter into a policy of pretence after the birth: "Well, you dress up the baby in a pretty dress, and you put on a new dress and smile as if nothing had happened. Because women NEVER look as if they've had babies. It's such a big, gruelling experience and here they are, all shining and clean after it. As if nothing had happened. The baby looks such a pretty wee thing instead of a struggle. I could hardly believe that everybody had babies when I was having her because nobody acts as if they had. They don't seem to have been affected by it all. They're still daft - you know, they don't seem to grow up. They still put on their soul make-up and they're away dancing." Thus Joan thought that birth should involve a maturation process and she was shocked when women seemed to try to negate its intensity and importance. Perhaps some women did exaggerate the intensity of the pain (for instance, Joan told me afterwards that she would have liked to have

exaggerated her suffering to her husband but she could not because he had been with her throughout her labour-). If women do exaggerate, there would seem to be good reason for doing so. Ritual is a means of divesting a person of his former status and investing him with a new status (25). Perhaps it is because society fails to provide any ceremony or ritual to mark the entry into motherhood that women are prompted to exaggerate the pain they suffered during labour. As Fortes says, "Ordeals and mutilations are more than conspicuous ways of emphasizing entry into a new status " (26).

But perhaps the woman is not the only one who should try to work out ways of coping with the pain. Watching a birth can have a profound effect on the husband too, as Maggie found: "Jeff stayed with me all the time. And when she was born, I says to him, 'Never mind, we'll have a boy next time, Jeff.' And he says, 'But I couldna go through that again.' I says, 'But you never went through anything!' But he says he sort of felt as if he was going through the pain as well with sitting beside me."

CHAPTER NINE: IMAGES OF THE BABY

This chapter, in many ways, provides an introduction to Chapter Ten, which discusses how the women coped with their babies during their early days as mothers. The women did not wait until their babies were born to begin developing images of them and working out how they were going to behave towards them. Instead, they had already thought about their babies when they were pregnant, developing their images of them and "working them through" before they were born (1). In this way they were seeing their babies rather as problems to be solved by rational techniques, one part of which is to try to work out solutions to problems before they are actually tackled (2). This meant that, by the time they first saw their baby, some of the women already had a fairly vivid picture of it - a picture which they sometimes found was rather far removed from reality (3). This chapter describes some of the more common images which the women developed and discusses how some of them were broken or reinforced. Chapter Ten goes on to consider how the women's perceptions of their babies in conjunction with other images and beliefs influenced maternal behaviour.

Discussion.

All the women saw their babies as something to be proud of and to show off. Sheena said, "I was dying for somebody to come and see him because I couldn't show him off to anybody! So I took him to the place where I used to work because they wanted to see him. It's great when somebody makes a fuss of him!" As Aries (4) has said, from perceiving children as miniature adults and allowing them no separate status, Western society has become increasingly child-centred. My women saw babies as important and precious members of the family who therefore deserved the best (some of

of the implications of this image are outlined in the discussion of baby things in the next chapter.) This image of the baby as something to be proud of was related to the premise that a mother must be seen to love her child, which is also discussed in Chapter Ten. Relatives felt that they had a right to a share in the glory of a new baby. One of Wendy's sisters, for example, went to great lengths to persuade a friend to lend her her pram so that when Wendy visited she would be sure of being able to wheel Jason round the neighbourhood.

But perhaps partly because so much attention was lavished on babies, the women recognized them as also being a potential source of family friction. This was illustrated by the care they took in choosing a name for their children. Rossi (5) has described how American middle-class couples tend to name their children after relatives and how this has the effect of strengthening family ties. My women, however, were extremely reluctant to name their children after relatives, despite some instances of considerable family pressure, because they saw this as slighting other members of the family who were not so favoured and possibly even leading to a breakdown between the two sides of the family. For example, Helen said, "I'd feel you were favouring one more than the other. You know, picking their name. Say you didn't have any more, and there's one been favoured with one of the grandparent's names. You've got to watch. And it could lead to trouble. I don't think my mother would be hurt, but it could happen, you know. You feel you might make the situation arise by doing this. Because, you know, people can be funny, and families, I think, are the funniest of the lot." It was almost as if both sides were keen to claim this new baby as their own and were jealous of any success the other side might have. (This was reflected again later in relatives' eager claims that the baby resembled their side of the family rather than the

other.)

Another reason why the women preferred not to give their baby a family name was because they saw the baby as an individual, somebody who ought to have his own, unique name. They thought that a family name would mean that the child needed "another handle as well to distinguish who's who," and the inevitable "big John/little John" syndrome. They all disliked this because of their concern that there should be no confusion as to the identity (and individuality) of their child.

However, despite their image of their baby as a unique individual, when they were pregnant many women believed that young babies were "all the same." By this they meant that babies looked alike and behaved in the same, uniform way, simply spending all their time eating and sleeping. The girls who held this image most strongly were the ones who had had little experience of babies. But once their babies were born this image was shattered. The period in hospital gave the women time to observe other babies and led them to decide that all babies were different. They saw that babies looked different from each other and that they had different sleeping and crying patterns. Some women also found that their baby's behaviour was far from the easy routine of eating and sleeping which they had envisaged, and this could make them feel surprised and anxious, as the case study of Helen in the following chapter demonstrates. In extreme form, this image of babies as different from each other led to some girls' seeing their baby as absolutely unique. This image formed an important basis for the belief that only the mother can understand and cope with her baby, which is discussed in terms of perceptions of motherhood in Chapter Ten.

The assumption that baby boys and girls were inherently different types of creatures was usually firmly established by the time the baby was born.

That is, the women assumed that children were not so much socialized in to different sex roles, but were different from birth. In particular, they assumed that baby boys and girls needed to be amused and controlled in different ways. This assumption underlay Elspeth's desire for a son:

"I never had a brother, and wee boys are more sort of NEW to me. I'm USED to wee girls... But I'd be lost with a boy! I know how to play with little girls and how to amuse them, but when it comes to little boys..."

This assumption therefore had implications for how well a woman expected to be able to cope when she was finally confronted with her son or daughter. Her job as a nursery nurse had enabled Julie to develop this assumption more fully than most, and had led her to the conclusion that little boys were "easier to bring up" than little girls. She based this on her perception of little boys as more "affectionate," more willing to be persuaded and as being merely "mischevious" rather than "cunning and sly."

These background images of little boys and girls influenced a couple's desire for a son or a daughter. Unlike the women interviewed by Klein, Potter and Dyk (6), most of my women expressed a clear preference. Those who did not (usually because of their fears for their baby's well-being, in that they saw voicing a preference as a presumption which might bring them bad luck) generally later confessed that they had secretly entertained a preference. Helen's husband was an example of someone who based his decided preference for a girl largely upon his ideas about boys' and girls' personalities: "My husband wants a little girl. He says, 'If you have a little boy and it's anything like me when I was young, it'll be a wee terror.' So he says, 'It'll be better if it's got your placid nature.'" Note his assumption that heredity plays an important part in shaping a baby's personality. His beliefs eventually influenced Helen,

with the result that when she found her daughter was a 'cry baby' she was more surprised than she might otherwise have been (see the case study in the next chapter.)

Many women believed that they "knew" the sex of the child they were carrying. Sometimes this was merely wishful thinking, but more often their "knowledge" was based on or reinforced by various superstitions or 'tests' which purported to predict the sex of the foetus. Such tests are not new. Forbes (7) has described some of the numerous tests that have been devised through the ages. Some have concentrated upon the nature of the woman's urine, others upon her physical condition. He also mentions tests where the sex of the child was said to be revealed by the expectant mother's actions. For instance, in medieval England, she was offered a lily or a rose. If she chose the lily, she would have a son; if the rose, a daughter. My women were aware of several tests, of which the most popular were prediction by shape (if the woman was carrying her baby "high" and to the front it signified a girl; "low" and to the back, a boy), and the needle test. In this test a friend holds a needle on a string above the woman's hand, or preferably, her stomach. If the needle swings in a circle it means that she will have a daughter; if it swings in a straight line she will bear a son. Although very few women expressed outright belief in these superstitions, some seemed to be influenced by them ("it makes you think"), especially if the tests had, in their experience, been proved right in the past. More women were indirectly influenced. For example, girls found themselves beginning to think of their baby as a particular sex simply because others repeatedly told them that it was - and their "knowledge" was based on the tests. Therefore if a woman had developed ideas as to what baby boys and girls were like, and if she also "knew" the sex of her baby, she had already

formed fairly definite images of her baby before she even saw it.

The last group of images turned on, in some senses, opposing perceptions of babies: on the one hand there was the image of the baby as vulnerable/resilient (which was concerned with the baby's need for gentle handling), and on the other was the image of the spoilt baby (which was concerned with the baby's need for firm control).

When they were pregnant most women thought of their babies as very vulnerable. They expected to be "frightened" of their baby - that is, they were apprehensive lest in handling their baby, they harmed it. This image was closely linked to one of the premises behind maternal behaviour (the mother must not let her baby suffer in any way) which is discussed in the next chapter. Those women who had had little to do with children tended to be "frightened" precisely because of their inexperience, but even women who were familiar with babies sometimes expressed fear at the prospect of looking after their own child because they felt "it's different when it's your own." Thus their sense of responsibility of motherhood eroded their confidence with babies.

However after a few days or weeks of caring for their child, most women found themselves becoming more confident. Central to their growing confidence was their replacement of the old, vulnerable baby image with a new image of the baby as resilient and able to withstand clumsy or rough treatment. The hospital staff often unwittingly helped the women effect this change. When they saw the nurses handling the babies much less gently than they did with no obvious adverse results, the women began to think that the babies were not so delicate as they had first thought. As Moira put it, "You learn in the hospital that they're not china." The fact that it was the nurses who were treating the babies like this also encouraged the women to adjust their image, as in their eyes the nurses

enjoyed the status of experts who knew what they were doing. (The behavioural implications of the perceived status of the advisor is discussed in the next chapter in the section on appropriate sources of advice.) In addition, mothers were more ready to see their babies as resilient if they thought they were big, sturdy or "solid" rather than fragile, small or delicate. The sheer passage of time was also instrumental in showing mothers that babies could withstand occasional rough treatment.

I said earlier that in thinking through their babies during pregnancy the women were seeing them as problems to be solved by rational techniques. An important example of this was the question of the spoilt baby. Most women worked out their beliefs about spoilt babies well before their child was born, and these became central guiding principles during their subsequent interaction with the child.

The image of the spoilt baby was probably the most significant image of all, in that it was extremely common and it held so many implications for a mother's behaviour towards her child. In their Nottingham study, Newson and Newson (8) reported a wide-spread dislike of spoilt babies. The definition of a spoilt baby can differ enormously (i.e. is in itself a problem) but my women seemed to use it to refer to a baby whose parents had so indulged it by giving it constant attention that it now demanded attention as of right, with the result that instead of the parents being in control of the baby, the baby was in control of them. This prospect was anathema to the women, who believed that a "good" mother should always be in control of her baby (see the next chapter for a fuller discussion of this.) Their understanding of a spoilt baby was based on a number of beliefs about the nature of babies and their cries. Firstly, they believed that babies cried for different reasons. Secondly,

they assumed that babies exhibit moral behaviour (9). A "good" baby was one who slept for long periods (and certainly all through the night) and cried very little; a "bad" baby would sleep only fitfully and cry for no apparent reason. Hence, when, as Chapter Eleven describes, Ruth's Baby stopped crying and began sleeping through the night she told me proudly, "He's got good and he's getting better." They therefore assumed that babies, even babies of less than eight weeks, were capable of conscious actions, and able to manipulate and plan ("from the minute they're born, they're fly" (10)). In order to be able to act on their beliefs mothers had to be sure that there was a comprehensible difference in the cries - and that they could work out the difference. This explained the anxiety some of them felt during pregnancy when they wondered if they would be able to "tell the difference." All of them agreed that it was right to pick the baby up if it seemed to be in real pain (the baby must not suffer (11)), but they thought that lifting a baby when it was merely crying for attention would, sooner or later, lead to its being spoilt (12). Knowing how to interpret the cries and how to respond to them therefore became a very real dilemma.

Judith worked out her beliefs about spoilt babies fairly comprehensively when she was pregnant. She saw babies as conscious and manipulative: "I think the baby knows instinctively if it's going to be lifted, things like that. And I think right from the very beginning you have to let the baby know that you're not going to be conned into lifting." She saw crying as central to the battle for control: "Because I know that I've HEARD - and now I'm going on hearsay - you know, that a baby will cry and that ... I think, from the start, a baby could rule you - could sort of rule your life if you sort of - well, if you make the baby your whole life, which I don't believe in. I think the baby should fit into your

life, not you to the baby's. And I think a baby sort of KNOWS this from the start, that if it's going to cry you're going to lift it - or you're going to rock it. Therefore it knows it's going to get attention if it cries, so it'll cry all the more." Basic to this approach was her belief in a comprehensible difference in cries: "Of course, there's a difference in cries, you know. There's a sore cry when there's something WRONG with the baby, and then there's the cry that well, there's just no tears, you know, it just wants ATTENTION! And I think it's to be able to distinguish between.... THAT'S something that bothers me a bit." She tried hard to reassure herself that she would be able to "tell the difference": "I think it maybe just comes, you know, instinctively - that's the only thing that I can think of. But it does bother me."

Conclusion

This chapter showed that the women built up a picture of their babies sometimes months before they were born. The most common images focused on ideas of individuality and uniformity, and the baby as a creature in need of gentle treatment or firm control. They saw the baby as at once something to show off and a potential source of friction within the family. They were concerned that it should be seen as an individual with its own clearly defined identity, but before it was born, several women believed that young babies were "all the same." It was not until they became mothers and had had more experience of babies that they decided that they were "all different." They assumed that little boys and little girls were inherently different. The women initially expected their babies to be vulnerable to their least mishandling, but gradually came to see them as remarkably resilient. The chapter ended with a discussion of what was probably the most significant image, that of the spoilt baby. These images

had implications for the way the women eventually reacted towards their babies. Chapter Ten goes on to describe how the mother's image of her baby, in conjunction with other relevant images and beliefs, influenced her behaviour towards her child.

CHAPTER TEN: COPING WITH THE BABY

This chapter looks at how the women coped with their babies. Babies behave differently, and the way that they behave, together with their mother's definition of their behaviour, affects the way their mothers respond. The chapter begins by describing some of the premises governing maternal behaviour. It shows that the girls' ideal was a quiet baby and a clean and tidy home. The rest of the chapter considers how they tried to achieve this ideal. If the baby cried incessantly for no obvious reason, then life became a search for cues and advice. However, not all sources of advice were considered equally acceptable and the next section describes some of the variables upon which acceptability depended. Feeding a baby solids was an effective way of quietening it, but their use generally brought the mother into conflict with her Health Visitor. The chapter ends by discussing the ways the women negated the Health Visitor's advice and thereby 'allowed' themselves to continue using solids.

Normative Premises Governing Maternal Behaviour.

Faced with an uncertain world, the women had to rely on premises, beliefs and expectations about motherhood which "passed for knowledge" (1). A normative premise is something which is taken as a basic prerequisite for action. In other words, it is a normative constraint which is so much of a constraint that all other action is, at least in theory, influenced by it. Three of the more important premises governing motherhood were: the mother must love and be seen to love her baby; she must not let it come to any harm; and she, not the baby, must be in control.

(a) The mother must love her baby.

Judith's belief that a mother must love her baby explained why she felt guilty at confessing, "I felt a terrible mother because I could sort of RESENT Christopher a bit, you know." Linked to this, and based on the image

of the baby as something to show off (2), was the feeling of pride which the women expected to feel in their baby. Lynne equated motherhood with pride when she explained away her initial lack of love for Adam as the influence of the drugs she had received during labour: "But as soon as the effect of the drug had worn off, I was alright. I mean, I was quite a good little mother, I felt quite proud." The key word here is "alright." Lynne used "alright" to suggest her idea of the correct way to behave - which was to feel proud of and loving towards her child ("a good little mother.").

However, this premise that a mother must be seen to love her baby, together with the image of the baby as a source of pride, brought with it its own constraints. For example, it meant that most women did not want second-hand things for their babies. Baby things acquired a symbolic value and became the outward sign of the parents' love for their baby, as Anna explained: "It's to show the world how much you want your baby. You know, BUYING everything. You buy everything - things that you dinna even really need, you buy. And this is because you're wanting your baby to have everything. You dinna want it to have anything second-hand. You want her to have everything RIGHT." Perhaps part of their thinking here was that the baby was an important member of the family (it "completes" the family) and it therefore deserves the best. There was probably also the wish to give the baby a good start in life.

This conviction that new things were right and proper meant that if the women, through economy or the desire to avoid hurting people, felt obliged to accept second-hand things, they also felt obliged to explain away their taking them. Thus Helen explained that the pram her sister-in-law had offered her was in good condition as it had "hardly been used." The most important factor was that it was her sister-in-law's, and "I know where it's COME from, you know. And she's clean."

Their belief that they must love their child led to other constraints. For instance, it deterred some women from acknowledging that they would prefer a son or a daughter as they thought that entertaining a strong sex preference could lead to "rejected" babies. By this they meant that the mother might feel so disappointed that she "rejected" her child if it was of the 'wrong' sex, and that the baby itself might feel "rejected" as it might be able to sense that it was not what its mother had wanted. This was why, when women did express a preference, they usually added the rider, "...but if it's a boy/girl it'll not make any difference. It'll get treated just the same." This rider thus 'allowed' them to state a preference.

Similarly, once the baby had arrived the women found it difficult to express any open dissatisfaction. Therefore if they did have difficulty in coping they expressed their feelings indirectly in jokes. For example, they joked about "sending the baby back," or "trading it in for another model." These jokes turned on the fact that, unlike material goods, the babies were here to stay.

(b) The mother must not allow her baby to come to harm.

The product of loving one's baby is ^{the desire} to prevent it from suffering in any way. Rossi (3) has remarked that the transition to parenthood is difficult because of the abruptness with which women are catapulted into a twenty four hour responsibility for their baby. My women were very conscious of what they termed the responsibility of being a mother. The term 'responsibility' expressed their obligation to see that their child came to no harm. Jean expressed this when she discussed her attitude towards baby-sitters. Her comments here also showed some of the constraints which this premise could impose: "I wouldna leave her because there's too many things happen with baby-sitters. I heard of one woman that lost her bairn that way. The lassie let the bairn fall on its head and gave it

meningitis. So I wouldna leave her. If anything happened to her, I'd kill myself. Because, as I say, you're responsible for them, it's your bairn. She's only an innocent wee soul and she doesna ken any better. And if anything happens to her, it's your fault. You canna blame fate for that. It's up to you to look after them." Jean's dilemma here was one of trust. She believed that people were not necessarily what they seemed ("For all you know, I could be a murderer.") Therefore she felt that she might invite some one to baby-sit only to discover that he was unreliable. This was a risk she was not prepared to take (4).

Linked to this idea of responsibility was the image of the baby as resilient/vulnerable which was explored in the previous chapter. Jean saw her baby as vulnerable ("She's only an innocent wee soul and she doesna ken any better"), which heightened her anxiety. The more resilient the women believed their babies to be, the less apprehensive they were that they might harm them.

Most of the women tended to see hurting their babies in purely physical terms. Sophie was unusual in thinking in developmental terms. At one point she mentioned that she felt it was her responsibility to see that her child grew up into a "good citizen ... a responsible adult" rather than "one of these little thugs running about with their spray paint."

(c) The mother must be in control of her baby.

The women tended to think of their babies in rather authoritarian terms and implicit in much of what they said was the premise that they should be in control of their child. There were two points here. Firstly they thought that as mothers they should be able to stop their baby from crying; and secondly, they felt that the baby and its care should not prevent them from having a clean and tidy house. Both points are related to the image of the spoilt baby which was discussed in the last chapter.

The first point was nicely illustrated by Judith: "The first Monday I was

on my own with him he cried all day. Well, I was at my wit's end, and I FED him and he went down and he CRIED. And I thought, 'Oh, I can't STAND it.' I felt like saying, 'Shut up! Shut up!' I didn't know what was wrong with him and I was just about round the bend.... So my Mum had phoned about half past four and she said, 'How are you getting on?' and of course, I burst out crying. And so Mum said, 'I'll come right over!' So she got a taxi and came over. And my Mum had tried, 'Shush, shush, shush,' and she said, 'That's him down now.' And she put him in his pram and he started again. I said, 'See!' (laughter) I was about delighted that he did, because I thought, oh heavens, if she comes and puts him down I'll look a right - (laughs). Anyway, she 'Shush, shush,' and he went to sleep, you know. And I thought, oh dear, it's ME. I'm an awful mother, I can't keep my child quiet. And she put him in the pram and he started screaming. So I said, 'Oh, oh! I'm glad, now you see!' " The important sentence here is, "I'm an awful mother, I can't keep my child quiet." Judith felt so strongly that she ought to be able to keep Christopher quiet that she was even willing to endure yet another screaming bout in order to be reassured that it was not her ability as a mother which was suspect.

Secondly, the women were concerned "not to let the baby take you over completely and be in a perpetual muddle." All the women (except Joan, who adopted a more bohemian life-style) were very house-proud. This was illustrated by Brenda's shocked incredulity at her Health Visitor's suggestion that during her first few days home she should ignore her house-work in favour of caring for her baby. It was easier for their babies to "take them over" if the girls devoted a lot of attention to them when they cried for no clear reason. The time they spent in worrying why the baby was crying was time they were unable to spend on their house-work, as the case study of Helen later in the chapter shows.

The last chapter showed that because most of the women saw their babies as manipulative and because they were determined not to spoil them, there were powerful constraints against cuddling a baby who was crying for no apparent reason. The women therefore had to find other ways of coping with a 'cry baby'. A popular way was by imposing a routine on the child. The women all seemed to prize organizational ability (for example, see Helen's proud comment, "I was an organized hairdresser.") Perhaps this predisposed them to favour routine as a way out of their dilemma. By imposing a routine, the women were essentially imposing their will upon their children - they, rather than the babies, were dictating the order and pace of events. Routine was seen as the way to prevent "muddle" (that is, the babies controlling events), and it thus became the symbol of control. Sophie, for example, in reply to my asking if Jane was proving more work than she had expected, answered, "Not really, once you get into a routine. When she's unsettled she sort of keeps crying, and you pick her up and see what's wrong with her, THAT'S when things tend to get left behind." (That is, when routine had to be abandoned.) "I like to work to a routine, and as far as possible to stick to that. After the first couple of days I got things set out in my mind, you know, when I wanted to do things, and I stuck TO that." The idea behind routine was that the mother could organize things so that her baby did not take up an inordinate amount of time: "Of course, there's things you do change. Sort of change your routine. For instance I was bathing her in the mornings. Well, once I started putting her into dresses I bath her in the evenings, which I find's a lot better because it takes up less time." However, not all women were able to develop a routine as rapidly as Sophie. The ease with which they did so depended in part upon whether they saw their baby as irresistible or not (this is amplified in Chapter Eleven). Another way of quietening a baby was to feed it solids, usually in the

shape of cereal. This method was effective but contentious. It is not a new method (5). For instance, what, by modern standards would be regarded as over-feeding was widely practised in nineteenth century America in order to pacify babies. They were given dainties, cakes and 'pap,' (moistened meal or bread served in bowls like gravy boats), and sometimes drugs such as alcohol, laudanum and opium (6). Current medical thinking suggests that too early feeding of solids can be bad for a baby (7), and most of the Health Visitors seemed to have adopted this position. However, some mothers found their babies so fractious that they felt that mixed feeding was the only solution. This led them into the difficult dilemma of, on the one hand, wanting to obey their Health Visitor but on the other, wanting to quieten their baby. For example, Judith described how she "wanted to do what was best for Christopher." She believed that what her Health Visitor advised her must be right and so when, during a particularly exhausting period, she suddenly decided, "Oh, to pot! I'm going to put him on farlene," she told me, "I felt as if I was murdering him, I felt so GUILTY." Therefore if the girls wanted to feed their babies solids it was essential that they should be able to persuade themselves to disregard their Health Visitor's advice. How they managed to do this is discussed in the last section of this chapter.

The women therefore wanted to have a clean and tidy home and a quiet baby. A quiet baby was a contented baby and one which was not in control. Their problem was how to achieve this. If the baby cried a lot and refused to be pacified the women faced considerable problems. In the early weeks it is often difficult for a mother to interpret her child's cries because at that stage the baby cannot be expected to know the shared meaning of interaction. Man lives in a symbolic universe where behaviour and all other social objects of study are "interpreted" by the

individual and have social meaning (8). The mother finds her baby's cries problematic because the ground-rules which she normally uses in order to pick her way through social interaction are lacking. She is therefore forced into a furious search for cues which she has to interpret according to the only rules she knows - those she uses in interaction with adults.

Appropriate Sources of Advice.

In addition to searching for cues most mothers also sought advice. They did not regard all advice, however, as acceptable. Whether or not they accepted advice depended upon several factors, particularly their perception of motherhood, self image, perception of the adviser, and their image of their baby and its behaviour.

For instance, there were three main perceptions of motherhood. If the mother believed that one learnt about motherhood primarily through the experience of being a mother oneself ("there's nothing like the real thing"), then she was less likely to listen to the professionals (especially if she thought they were childless) and more likely to listen to other mothers. Alternatively, if she perceived appropriate qualifications as the better basis for knowing about motherhood ("who better to ask than somebody who knows, who's qualified?") she would be more likely to listen to the 'experts' and less likely to rely upon lay people. Opinion was also divided as to whether there were right and wrong ways of behaving as a mother or whether virtually anything that one did was permissible. Judith assumed that there were right and wrong ways ("I wanted to do what was best for Christopher"), whereas Sophie's opposing belief that there were "no hard and fast rules" is elaborated in the following chapter. If a woman who believed that there was no right and wrong way received conflicting advice from professionals she was then quite likely

to see all advice as merely personal opinion.

These perceptions of motherhood were related to different images of the baby. For example, those mothers who believed that there were right and wrong ways of behaving tended to see their babies as vulnerable and believe that their actions could easily harm their children. Helen was an example. She decided to ask the Clinic if it was alright for Clare to sleep all through the night, "Because I wouldn't like to be doing her any harm. I wouldn't like to think that she was being deprived of anything because of missing that feed." However, those women who did not think in terms of right and wrong ways were less likely to believe that their behaviour could adversely affect their child ("It's all just common sense, I think. I mean, everybody comes up alright, don't they? Even the worst treated baby.")

The previous chapter mentioned that some women saw their baby as a unique individual who could only be fully understood by its parents. This belief was based on the assumption that it was familiarity with that particular baby which counted, and that generalizations about babies were inadequate in so far as telling you how to cope with your own baby was concerned. As Jean said, "I could take her up to my mother's and go up to the club just up the road and leave her when she's older, when she can TALK and that to my mother. But the now you couldna leave her, because if she was greting and my mother didna ken what was wrong with her they would have to phone for me." Interpreting a baby's needs is problematic because, as I said above, the baby cannot interact in the normal adult way (as Jean implied, the baby cannot speak). Therefore these mothers felt they were in the best position to interpret their baby's behaviour because they believed that their baby's cues were completely individual to that child, and, by dint of being with their baby more regularly than any one else, they felt that they had learnt how to understand the cues.

Self image was significant too. If the women felt confident as mothers (perhaps because like Maggie they had had a lot of experience with babies already) they were less likely to feel the need of advice. However, if they lacked confidence and saw themselves as "learners," they welcomed it ("I said, 'Well, Mum, I'm only learning, so I'm quite pleased with your advice.'")

Another determining factor was the girls' perception of the person who was giving the advice. Status was important here. For example, doctors generally enjoyed high status and were therefore listened to ("Well, they ken best, sort of style.") Otherwise, as we have seen, status depended upon whether the women felt that qualifications or experience was the most important factor in motherhood.

Their perception of the way in which advice was given also played a part. The girls were more likely to listen to people who seemed confident of what they were saying, but who advised them rather than told them what to do. They also liked people who were pleasant and seemed interested in them, and who did not make them feel ashamed of their ignorance.

Chapter Four discussed the significance of the belief that ideology changes rapidly. If the girls believed that ideas about child care changed rapidly, they were reluctant to pay attention to people who tried to give them what they saw as old-fashioned advice. This sometimes meant that they disregarded their mothers and mothers-in-law in favour of their contemporaries' advice.

And lastly, their perceptions of their babies' behaviour influenced whether or not they listened to advice. The women who looked for advice were those who saw their babies as being unduly fractious and defined this as a problem (see the next section). But Joan, for example, took no

notice of advice because she saw Delia as a very contented baby and therefore felt that advice as to alternative ways of handling her was superfluous. On the other hand, Wendy's son was a 'cry baby' but she did not look for advice because she did not define this as a problem. Instead she persuaded herself that as Jason had cried continually in hospital when he was under the care of the medical staff (experts), his crying could not be attributed to her bad mothering. And, precisely because he had cried from the start, she was able to see his crying as a manifestation of his personality rather than a sign of "something wrong."

These ideas about advice form an important background to the final two sections.

Helen and the Girnie Baby: A Case Study.

This case study charts Helen's difficulties in interpreting her baby's cries and in finding a solution to them. This was an area which was fraught with uncertainty. Throughout the episode Helen tried to act in a rational fashion (9) in accordance with the beliefs that passed for knowledge in her mind because these were the only guiding principles she had. The background beliefs about spoilt babies which were explored in the last chapter are central to an understanding of her experiences. Perhaps because of the high evaluation of rationality and the scientific method, most of the women were concerned to behave rationally. But this could be difficult if, like Helen, they were faced with a "girnie" baby (10). Some women might have thought that following their mothers' advice was behaving rationally, particularly if they set a high evaluation on experience. Some women did turn to their mothers, but Helen's mother felt unable to help as the baby behaved in a way which was completely foreign to her. Helen, and other mothers of 'cry babies', then, encountered the problem of two unknowns: first they faced the cognitive problem of

recognizing what was wrong; and secondly, even if they could identify what was wrong and the goal which they were working towards, they still had to find out how to reach it. Furthermore, even if a particular solution seemed successful, there remained the possibility that the diagnosis might still be wrong. Helen's description of motherhood illustrated her emphasis upon rationality (see the language she uses: "analyze," "super-efficient," and elsewhere she uses the term "logical"), and how far motherhood was to her a difficult learning process: "You have to learn a lot of things really. You've got to sort of analyze your baby and try to find out what suits it and all this. You know, you just learn day by day, really. I think CERTAIN things come by instinct, but you've got to learn as well. I don't think everybody's made a super-efficient mother right from the start. I don't THINK so. There might be people that's just got that way, but I doubt it. Unless they've been a nurse, a mid-wife, or something like that. In that kind of line so they know. But I think you've got to learn." Helen saw herself as a learner as a mother. She had had very little experience of children and was therefore ignorant of many aspects of motherhood. She tried to tackle this problem in a rational manner during her pregnancy by attending Mothercraft Classes and preparing herself before the baby arrived. She thought that the Classes could help because she believed that motherhood was like a new job for which she had to be trained (note her assumption that motherhood can be learnt.) It was therefore not surprising that when she eventually became a mother she felt that motherhood was more a question of learning rather than instinct. (It was only girls like Maggie who were familiar with babies who thought that motherhood "came naturally.") Helen felt confident that she was receiving sound advice at the Classes because it was a nurse who ran them, and "she's dealing with this sort of

thing all the time." Reliance upon 'experts' was a theme which ran right through Helen's early experiences with Clare. Although she listened to lay people (her aunt, for example) she preferred to be advised by professionals. This preference was linked to her beliefs that there was a right and a wrong way of handling children, and that a mother could harm her baby by her behaviour towards it. Her image of her baby had a great influence upon her behaviour towards Clare. Helen and her husband had expected a daughter to be just like her - quiet and placid - and that they would automatically be in control. They were unprepared for the way Clare did behave. Helen told me, "As a new baby I thought she would just eat and sleep. But she didn't DO that, you know. And, of course, my mother was the same. She said, 'Oh, this is unusual. She should eat and sleep.' Because apparently I did that. And I was quite contented. And Bob's mother said he was quite contented. So I don't know where she got this discontentment about."

Because she had expected a quiet, placid baby Helen was immediately bewildered by Clare's repeated crying. She defined Clare's behaviour as a problem for three reasons. Firstly, it seemed odd because it was unexpected. Secondly, her expectation of a quiet baby had been reinforced by Clare's not crying in hospital. This also meant that Helen was unable to use Wendy's coping mechanism of persuading herself from the start that it was her baby's personality to cry. And thirdly, Clare's crying was inexplicable in terms of Helen's ^{basic} working belief that if a baby had been fed and winded and given a clean nappy it should sleep - a belief which was being continually reinforced by the experts, the District Nurses and the Health Visitor.

Therefore Helen's immediate reaction was one of blank uncertainty: "To begin with I was awful uncertain about this, because I didn't know. I

couldn't really understand the cry." She interpreted it as "a hard cry," that is, a sign of "something wrong" which was causing Clare pain ("And I thought, well, what can be wrong with her?") In accordance with the premise that mothers ^{must} not allow their babies to suffer, Helen began her search for explanations and solutions.

Given her basic working belief outlined above, she began by trying to check that Clare had been adequately fed and winded. As she was breast-feeding she was unable to see how much milk Clare was taking, and so she turned to the experts, the District Nurses, who watched her feeding and reassured her that all was well. Later the Health Visitor also checked Clare's feeding: "She says, 'Is she due a feed?' So SHE fed her, and she was sort of watching her. And she says, 'I THINK what's wrong with her is she's got a very strong suck, and she's sucking the teat right in and getting air into her stomach. So she's getting milk and air, and milk and air,' she says. She maintained that this was what was giving her pains in her stomach and making her cry." The Health Visitor advised Helen to take the teat to the side of Clare's mouth and pull it out to let the air get back in. (This was in contrast to the previous Health Visitor who had advised Helen that Clare would stop when she wanted a rest and the teat - and air - would come out itself.) The Health Visitor winded Clare and laid her down, promising Helen that she would go to sleep: "And I thought, oh, that's fine. So she went away. She was away five minutes and she started to cry. I thought oh no! Not AGAIN, you know. So I started talking to her, and she did, she went off to sleep only about ten minutes after. And she seemed more SETTLED, and she slept longer. So I thought oh, this is the answer! This is it!" But her joy was short-lived: "But it worked sometimes and other times it didn't." Next, like most mothers, Helen thought the baby must have wind: "But there

was no wind. I kept trying to wind her, and she stopped crying as soon as she was in your arms."

The crying went on, and Helen was left thinking, "This is terrible."

Having confirmed that Clare was being properly fed and winded, she began to think that there must be "something wrong." First she wondered if the "little bloody bit" that had been left when the cord fell off was upsetting her, "so I asked them about that." The surgical spirits which the District Nurses suggested cleared up the "bloody bit" but Clare continued to cry. Helen then remembered hearing that nappy pins could dig into babies, "but she doesn't HAVE pins in her nappy, so THAT wasn't bothering her."

Next she wondered if Clare had pains in her stomach and tried gripe water as a panacea. It worked the first time, but proved to be an imperfect solution as Clare soon took to spitting it out. Helen described how, in desperation, motherhood degenerated into manipulation: "I had to get her at an angle ... and I put a piece of cotton wool over her mouth like that, to stop her spitting it out again! To make her swallow. You've got to be up to all the tricks of the day." But to her disappointment, Helen found that even when Clare did swallow it, gripe water was only occasionally successful.

As she was unable to "work out what was wrong with her," Helen began to wonder if it was her mothering which was at fault. In response to her repeated questioning, the District Nurses and Health Visitors suggested that she try different ways of handling Clare. They thought Clare might be happier lying on her stomach but to Helen's surprise, she refused to lie like that ("as young as she is!") Helen's surprise here was indicative of her shock at discovering her baby to have much more of a will (in terms of likes and dislikes) than she had expected. Then, on the

Health Visitor's advice she tried to help Clare distinguish between night and day by dressing her in night and day clothes and by moving her from the bedroom to the living room. However, this manoeuvre was unsuccessful as Clare refused to sleep in the living room.

By now Helen could only think that she was not "motherly enough." This supports Benedek's suggestion (11) that if a mother fails to find the 'right response' when her child is crying, she believes herself a bad mother. As we have seen, in our society mothers are expected to love their babies, but in her despair Helen was beginning to wonder, "How could I EVER love anything that's going to lie there and girm the whole time?" In addition, she had begun to see Clare as someone who tied her to the house, and this affected her feelings towards her: "And I was really getting to resent her at one point. Because of my depression, I really was, you know. And I didn't feel as if I loved the baby either (nervous laugh). I thought, I'll NEVER make a mother, you know." Helen was reduced to coping with these unacceptable feelings by joking that she had "wanted to send the baby back."

Like most of the other women, Helen had looked to routine to help her control her baby and she had expected to have no difficulty in establishing one, as she saw herself as an "organized" person. But because she was unable to solve the 'problem' of Clare's crying she was unable to get into a routine with the result that Clare remained effectively in control. And the fact that she was neglecting her housework in order to see to Clare only served to depress her further.

After a process of virtual elimination, Helen narrowed the crying down to two possible reasons. It was either a sign of something seriously wrong, "something internal, which I hate to think" - and so she repressed it; or Clare was spoilt, and crying because she wanted to be picked up.

Helen found the latter explanation more acceptable. She found it easy to believe because the idea had already taken root during her pregnancy when, like Judith (see previous chapter) she 'worked through' spoilt babies and vowed never to have one; and because friends and relatives were continually reinforcing it. She took particular notice of one such 'expert': "I've got one friend, and her friend, Marianne, fosters a lot of babies, and SHE seems to have plenty experience. And I was asking her about this crying carry on. And she says EXACTLY the same. 'No, no,' she says, 'I think she's wanting to be petted,' she says. 'If you want to stop, stop lifting her.'" This method depended upon Helen's ability to distinguish the cries: "'If you think the cry isn't hard, and she's all fed and everything,' she says, 'Just leave her lying. Don't lift her,' she says." She went on to give Helen a way of coping with the noise: "She says, 'Sometimes you can't bear this. It annoys you, the crying. But you soon get used to it,' she says." Marianne then emphasized the image of the scheming baby: "'But you'll find that they soon get to know as well.'" In order to persuade herself to accept this interpretation (or to justify herself for having accepted it) Helen reminded herself of Marianne's credentials: "So, she's fostered over a hundred children, I think. A lot. A lot of babies. New babies she's had too. And she seems to know what she's talking about."

Helen also felt that her own experience bore out Marianne's interpretation: "She was crying on Friday there when I had put her down, but I thought no, I'm not going to lift you. It was quarter of an hour, twenty minutes she was going at it and I thought oh, maybe I'll go and lift her, you know. And just as I was going to go and lift her, she fell asleep. So it just shows you, you know, you've just got to know that they're having you on."

Having decided on an explanation (Clare was spoilt) Helen now had the remedy to hand: when appropriate, she would do as the 'experts' suggested and leave her to cry. However, there was still a problem of degree. As we have seen, Helen believed that the way a mother behaved towards her baby could harm it. She did not want Clare to cry for so long that she suffered in any way, but neither did she want to pick her up too soon in case she defeated the object of the exercise and Clare "got to know" and became spoilt. Eventually her aunt reassured her that little girls did not come to any harm if left to cry - unlike little boys who could rupture - and so Helen then felt able to leave Clare for twenty minute periods. She summed up her understanding of Clare's "mysterious" behaviour by reinterpreting it and telling me, "But it's just her nature, I think. She was just a niggley type of baby. She just seemed to want to cry." In reinterpreting Clare's behaviour, Helen had also reinterpreted her cry. Instead of seeing it as a "hard cry" as she had done at the beginning, she began to see it as a "temper cry." Thus to Helen the cries were no longer a sign of "something wrong"; they had become a manifestation of Clare's temperament. She decided that Clare was spoilt and "niggley" simply because it was the first explanation she hit upon which she found acceptable and thought she could act upon. However, it was not necessarily the one which was the most rational (12).

Solids and the Negation of the Health Visitor.

We have seen that the women assumed that a good mother should be in control of her baby. In their terms this meant that she should be able to stop it crying. Mothers of 'cry babies' soon found that feeding them solids soon quietened them (13), but they also found that the Health Visitors tended to disapprove of this method. In order to continue using

solids they had therefore to explain away or negate the Health Visitor's advice. This final section shows how they did this.

I discussed earlier the importance of the status of the adviser. A popular way of negating the Health Visitor was to attribute more status to people who recommended the use of solids. Doctors (and their wives) were regarded as impeccable sources of advice. For example, Ruth felt quite justified in feeding Adam rusks because, "The doctor at home, his wife was spoon-feeding the baby from a little over three weeks."

Some women adopted young mothers who fed their babies solids as a reference group and followed their example. They told themselves that these mothers "looked ten times better" than they did (a significant incentive in view of the importance that the women attached to their appearance (14)). They heard that these mothers had "good" babies, that is, ones that slept through the night. And, despite what the Health Visitors had told them about solids and fat babies, these babies did not look fat. Therefore, if a woman felt desperate about her baby's behaviour and her lack of sleep, she could fall back upon these arguments and persuade herself that her Health Visitor was wrong.

The women's perceptions of motherhood and image of the Health Visitor were also important. For example, Sheena believed that experience was a firmer basis from which to advise than theory. She therefore thought that "a mother knows HERSELF." She drew support for her argument from the example of Dr. Spock. He was significant here precisely because he was a doctor and so carried high status as an expert: "All they're going by is books and theory. They've had no experience themselves... All they're going by is books you can read, like that Dr. Spock himself says he was responsible for all the brats in America - you know, he SAID that. And I mean, that's a DOCTOR! You'd think he'd know, wouldn't you? And I

just feel that,well,same with the Health Visitor. They've no really had any experience,so I don't see HOW they can tell you that you SHOULD do this and you SHOULDN'T do that." As I said above,much depended upon the way in which the advice was given. Sheena refused to listen to the Health Visitor partly because she told rather than advised: "I'm no saying I know everything about babies,but SHE says that you don't put them on cereal until he's taking a full eight ounce bottle. And I just feel that - I mean,it's O.K. to ADVISE you and say,'Well,I don't think you should do this and that.' But to say,'You don't do this,and you don't do that,' I don't think it's right,because I think a mother knows herself. After all,it's your baby." Because Sheena believed that "mother knows best," it followed that she would resent orders from an'expert' because they undermined her omniscience.

As a nursery nurse,Julie felt confident in her ability as a mother. She did not see the Health Visitor as a particular expert,but merely as another person,no better qualified than herself. Neither did she think in terms of right and wrong ways of behaving. To her,all advice was simply "points of view," and she believed that different people had different points of view which were all equally sound. She therefore concluded,"Well,I'm a person same as she is,and I'm deciding what I'M going to do."

As I said earlier,the image the women had of their babies influenced whether or not they heeded advice. Some women managed to negate the Health Visitor's advice by telling themselves that their baby was special in some way,and therefore the 'ordinary'rules' which she was using did not apply to it. Chapter Four showed how women persuaded themselves that "everybody's different" in order to cope with uncertainty. This belief in the variability of human nature was now transposed to babies.

Sheena, for example, believed that "all babies are different. Some babies can take milk, and other babies can't. You know, a lot of milk for him, I just felt as though it went right through him, it didn't SATISFY him. And for her to say, 'You don't do this until they're so many months old,' I just don't agree with it. I think all babies are different. And I think you know your own baby best." This argument therefore neatly reinforced her earlier argument that "mother knows best." Some mothers also believed that Health Visitors were generalizing from "the average baby" in their books, and they felt that because of this their comments did not necessarily apply to the unique individual in front of them.

Other women more openly described their babies as special. Kathleen told me, "He's a baby of about three and a half months now in proportion, you know, so what else can you do but give him solids?" Julie used a more popular version: "She's just a hungry baby. That's what my Mum said, 'She's just a hungry baby,' she said, 'You'll have to give her some thing else.' Because she was crying for her food, you see." There was probably some truth in all these images, but it only served to increase the women's problems.

A more obvious way to ignore the Health Visitor was to cast doubt on the validity of her advice. Some girls did this by assuring me that milk could not offer as much nourishment as solids, and that it was not "strong enough" to fill babies of two months. Kathleen even turned the Health Visitor's advice round as she told me, "It's the bottles that make them fat, you know. Big heavy bottles." Not surprisingly, if they felt the Health Visitor had been proved wrong in the past, the women were less likely to take her advice in the future. Maggie, for example, was told by her Health Visitor not to feed Diane rusks but to give her Bengers. Her trust in the Health Visitor was destroyed when she read that Bengers was

only for problem feeders.

And finally, in order to reassure themselves that it was safe to disregard the Health Visitor's advice, the girls applied a series of rough tests, some of which were: baby loves cereal because he eats it all up/ is not sick after it / he is generally in good health (even the doctor says so)/ and he is not fat (even the Health Visitor says so).

Conclusion.

This chapter has described what a difficult time the early days of motherhood can be for new mothers. Because of their beliefs about motherhood and control, the mothers' aim was to have a quiet, contented baby. The rest of the chapter has discussed the problems involved in realizing this goal.

This was a period of great uncertainty. Because a baby does not know the shared meaning of interaction, its cries are problematic. Mothers of 'cry babies' had to embark upon a frantic search for cues (as to what might be making them cry), and advice (as to how to stop them). Helen's experience illustrated the difficulties and frustrations inherent in this process. Her approach was essentially trial and error, and her solution was the first one she happened upon which seemed to fit.

Perhaps because the new mother is a novice, she tends to be assailed with advice; sometimes, as a possible way out of her uncertainty, she actively seeks it. Central to the problem of motherhood was the difficult question of who could be treated as a reliable source of advice. Whether or not a woman accepted advice seemed to depend upon several factors, including her self image, perceptions of motherhood, image of her baby and its behaviour and her perception of the status of the person advising her. If she thought her baby cried inordinately, in desperation a mother might

resort to feeding him solids in an attempt to quieten him. This method was usually successful, but as the Health Visitors tended to oppose such early use of solids, the women had to find ways of negating ^{their} advice. They achieved this in the main by attacking the Health Visitors' status as advisers, perceiving their babies as special in some way and therefore out with the normal 'rules,' and questioning the validity of their suggestions. In this way they ensured that they had "good" babies without feeling "bad" mothers.

Introduction.

This chapter discusses the different ways the women reacted to pregnancy and motherhood. Self image emerges as a very significant factor in determining these reactions. There were two polar self images: the wife/worker self image (with its slim,sexually attractive body image),and the pregnant/maternal self image (with its fatter shape.) The first set of women valued their role as wives and the independence their jobs gave them. They liked an active social life,and their appearance was important to them. The women in the second group,however,were less concerned at giving up their jobs and their social lives in their eagerness to become mothers. They were also less concerned about appearing attractive.

These self images were therefore partly mutually antagonistic,and can best be expressed as forming the opposing ends of a continuum. I felt that the women formed a continuum because they took up positions of varying intensity rather than falling into two distinct and opposing groups. The women at either ends of the continuum held very definite self images and attitudes towards pregnancy and their babies; those in the middle,however,had less dogmatic views,which tended to make them uncertain as to how they should act. The women formed the following sort of continuum:-

WIFE/WORKER

PREGNANT/MATERNAL

Sophie	Joan	Pat	Wendy	Christine	Brenda		Ruth Alison
Jean			Judith	Helen	Anna	Liz	Kathleen
			Shrila		Elspeth	Gina	Julie Lynne
			Pamela		Moirra		Sheena

The wife/worker woman and the pregnant/maternal woman differed significantly on several issues,and these variables could be taken as indicators of a woman's general position on the continuum. There were three crucial images: self image,body image and image of the baby. These three images had a large bearing upon whether the new mother adopted a strict or indulgent attitude towards her baby. There were also a

number of secondary indicators. These included general images of children, perception of marriage and its relationship to parenthood, attitude towards pregnancy and becoming a mother, perception of motherhood and choice of feeding.

This chapter describes three case studies. Sophie sees herself primarily as a wife/worker. Ruth is at the opposite end of the continuum; she illustrates the pregnant/maternal woman. Christine's case highlights the predicament of a woman caught in the middle. The main contrasts between Sophie and Ruth are then discussed in the summary. As appearance plays an important part in this discussion, the chapter on Body Image provides a useful background against which this analysis should be set.

The Case Studies.

(I) Sophie: wife/worker.

Chapter Six set out Sophie's perceptions of and her reactions to her changing appearance. It described how much she disliked the 'fat' pregnant shape, and how she clung to her slim, 'sexy' appearance for as long as she could. These reactions constitute an underlying theme throughout the following analysis.

Sophie held very decided views about marriage and the place of children in marriage. She maintained that marriage was not an institution solely for the purpose of having children. Failing to see children as providing any sort of self-fulfilment, she denigrated those women who wanted a family early in their married life by presenting them as being of lower status ("and they'd probably been shoved into their council houses, and never been able to do anything else because they'd had kids.") She coped with the social pressure to have children by persuading herself that she was the one who was in the superior position: "Then you'd expect people turning round, after the initial question of, 'No kids?' and saying, 'Oh, you're quite right. They're more trouble than they're worth!'".... So, in a way, although they seemed to be surprised, they perhaps envy you in some way that you HAVE managed to set up life as

such,without having them." (Sophie's self-persuasion here was similar to the way she coped with the women who made unflattering remarks about her appearance - she described them as "snide," but went on to say that no doubt this masked their envy at her being pregnant.(1).)

Sophie believed that the prime function of marriage was the accumulation of material goods. To her,these were the "necessities" of life. Consequently,she thought that having children soon after marriage led to resentment,because "you usually spend the next few years resenting the fact that you've sacrificed all the MATERIAL things in life - which, you know,after all,what's life about?" In her eyes,children took a decided second place: "If you want,material things lie first,and the children are after,because it's got to that stage in our society that kids are - you know,having babies,it's a luxury."

Many women saw a relationship between babies and material goods,but the nature of this relationship differed significantly from woman to woman. For example,some women were apprehensive lest their materialism engulfed them and prevented them from having children; they presented their decision to have a child as a conscious and difficult wrench from their present life-style. Helen told me,"I thought maybe you'd get TOO selfish, you know. You'd probably think,oh,you'd worked all this time,and you'd been able to buy what YOU wanted and get what YOU want,and the longer you stay without a family,I just felt maybe you'd get to the stage where you'd think,oh,maybe no,you know,we're enjoying ourselves too much."

Several women thought that the 'right' time to have a child was after they had accumulated all the necessary material possessions. (Thus Jean advised me not to have a baby "until everything else is right. (When) you've got your house all done.") But Sophie enjoyed a consumer life-style more for its own sake than because,in its early stages,it provided the basis for bringing up a child. She was at the extreme end of this continuum in her high evaluation of material possessions. She was at the opposite end from Maggie,for example,who believed that bearing children was superior to buying goods because having a child was a creative act ("It's something that we sort of achieve by ourselves it's really something that IS your own.")

Sophie saw marriage and parenthood as two distinct states,and she felt

that marriage was the more important of the two. She showed this, for example, when she said that she expected that her marital relationship would be big enough "to include another one." She found it hard to tell me why she wanted children (2). The reasons she eventually gave were grounded in her marital relationship: "Um, why? It's not anything I can put a finger on.... I think at a certain time in your life, in your marriage, I think a family needs kids. You know, a husband and wife need to become a father and mother to bring that something extra to their marriage as such."

Sophie drifted into motherhood rather than taking any very positive step towards it. It was significant that throughout her discussion, her main emphasis was upon herself. She said that she had not stopped using contraceptives because of a whole-hearted longing to have children, although she added that she had always "been of the frame of mind to have a family." Rather, she felt that children offered her something different from working in the same job until she retired, and doctors exerted pressure by telling her, "I was coming up to the time when I was leaving it a bit late to have kids, and you haven't PROVED yourself." In addition she wondered if her long period on the pill might be doing her harm. And so, when her prescription ran out, "I just didn't have the courage to go back And I started thinking, well, you know, imagine if you go along for years and years, taking the pill, and THEN you find out that you couldn't have any. What a waste of money, apart from anything else. And I thought, the doctor IS quite right, and if I don't really make the break and come off now and just leave it to chance, I probably WOULD go on and on, because, you know, you like the extra money coming in. And well, apart from anything else, I enjoyed my job I just made up my mind, and said, 'Right, that's it! And if I fail - become pregnant, we'll just have to tighten our belts accordingly.'" Sophie therefore saw pregnancy as a distinct departure from her normal way of life (see her phrase, "making a break ") which she perceived largely in terms of herself and money.

Her general images of children were negative ones. Children were noisy and disruptive ("shrieking kids" and "kids shouting and bawling in the

street"), and the terminology she used to describe them was dispassionate: "offspring," "the little treasure," (said coolly), and "smart little creatures." She presented children as calculating, demanding and self-centred, and disliked them for interrupting adults. She seemed prepared to make few allowances for them; instead, once they were toddlers she denied them any separate status as children and expected them to behave as adults. She explained, "I've always had this tendency to treat children as little adults, never as children. Because to me, that's what they are, little adults. You know, they're quite smart little creatures. I can read them like a book. They show off, if they're in strange company, and they'll be wanting something off Mummy or Daddy. And just the way they go about it, you know EXACTLY what's going on in their little minds. Maybe Mummy or Daddy'll say, 'Well, he's only four,' or 'He's only a child,' type of thing. 'Can't really expect too much.' And all the time the little monster's laughing behind its hand.... Well, to me, if you're in company, your child must learn, if you're going to treat them like a young adult, they must keep their place and have good manners like any other adult. It really- it's one of the things that DOES annoy me. It seems that you can't have a decent conversation with the parents because the child is all the time trying to butt its way in, and pirouetting across the carpet in front of you, so that you feel that you're never really getting the parents' attention to what you're saying, because the conversation STOPS and it's back to whatever the child is doing: 'Oh, don't you think that's clever?' Really, to me, this is all wrong.... I think they should tow the line. I don't like kids holding the floor." Therefore Sophie's attitude towards children was decidedly cool. She saw them primarily as being in conflict with adults (in contrast to Ruth's much more harmonious image.) Discipline was important to her, and she believed that children should "know their place" and not take precedence over adults (3).

The prospect of becoming a mother did not entirely satisfy her - she repeatedly told me that she was not the "highly maternal type." However, she tried to choose her words carefully when expressing these feelings,

perhaps because she felt that they were at variance with society's expectation that a woman must be seen to want her baby and become a mother. To this degree, she seemed to assume that society disapproves of 'tough' mothers. She tried to present her feelings in a more acceptable light by using stereotype and highly coloured language to make her picture of the "maternal mother" as unattractive as possible. Thus, talking to babies became "drooling," and mothers who did this became "doters." Sophie saw motherhood as a potential threat to her favourite identity of a wife and a worker (4), and part of her time during pregnancy was spent in thinking through her baby and working out how she could prevent motherhood from reducing her to "an object, THEIR mother." She arrived at the following conclusions: "I feel you should still try and keep your own identity, and try and keep up SOME of the things that you perhaps did before. I don't think that the child should take you over completely, so that everything's built round the child. I don't think you should be sort of FRIGHTENED to have somebody babysit for you once in a while, and go out and ENJOY yourself. I wouldn't like to change so completely that the child would be my life, and that would be it, as far as I'd go. I fully intend to take a job after a number of years, once the child goes to nursery school, or something, I'd like to take work. Apart from the money, just to have an outside interest. I don't see myself as producing a baby every year for the rest - dread the thought." Thus by pursuing a social life and working Sophie planned to keep motherhood at bay. Perhaps her difficulty in imagining herself as a mother stemmed from her negative feelings about pregnancy and motherhood. From the first she had been surprised to learn that she was pregnant because after eight years of marriage she had become so established in the wife/worker roles that she found any change in self image difficult to make. She saw pregnancy as a distinct and very different state. Note the limiting over-tones of her description of her "trapped feeling" : "I had quite.- I don't know how to describe it - a TRAPPED feeling, as such. In that I thought, O.K., I'm pregnant, there's nothing I can DO about it, and that's my

life-pattern set now, you know. Then, of course, you've got the inevitable, you know, the birth, and the nine months of pregnancy. You had to go through it. And all the sort of nasty things that I hear - you know, older people tend to go on about - and you think, well, that's it, there's no way out of it, really."

However, Sophie enjoyed the first few weeks of pregnancy because all the emphasis was on her: "There's the excitement of the family, and you feel yourself quite caught up in it. And everybody's talking about it, and, you know, you think this is nice, centre of attraction, as such." But after that she preferred to forget that she was pregnant. She saw pregnancy as "my trials and tribulations," and told me that she was "all for shorter pregnancies." She disliked being pregnant mainly because she regarded it as an ever-present constraint which hindered her from being her sociable, attractive self. She explained, "I think being pregnant is not a state I particularly like. Because although I can forget it most of the time, it's still HERE - it's a part of you. It's always there at the back of your mind, and it just stops you from enjoying yourself that wee bit more. For instance, if you go to a party, and there's everybody else dancing around, and drinking their drinks and eating all their food and everything. And there's you, sitting back, you know, having to bear in mind at times like these that you are an expectant mother and you've got to take it easy."

Because she preferred to forget that she was pregnant, Sophie was loath to enter into conversation with the other patients at the Clinic who would have reminded her of it. By her eighth month she had successfully banished it from her thoughts.

Significantly, throughout her discussion of her pregnancy, her emphasis was upon herself, not upon her baby. This was related to her image of the foetus as a thing rather than a baby. Sophie thought that she did not experience the "wonderful feeling" that she had expected "about new life starting, and my child, and all the rest of it," because she was unable to invest her foetus with an identity. Early signs of life

meant nothing to her because she considered them to be so vague (5). Instead she described the first kick in a detached way which almost bordered on distaste: "It was quite a weird feeling, really, that there was something IN there, and it's going to keep on growing." By eight months she was still not giving the foetus any identity, although by then she had got used to its presence. This was a very atypical reaction. And when I asked her if she saw her foetus as a baby or a thing, she alone of all my respondents found the question difficult: "Oh ---- that's a tricky one. (Pause). I think - I would reckon that, even at this stage in time, it's just something that's there. Because I haven't put a sex or a face - or any sort of physical attributes to it at all. Er, it doesn't HAVE an identity. It's a BABY, O.K., I know it's a baby, and I know it's in there. And if I think about it long enough, it's a nice feeling to think well, there is a baby in there. But I always feel just that bit detached from it. As I say, I've never spent that much time dreaming about what it's going to look like Well, obviously it can't have an identity just now. It's just a baby. Until it's born, until it's actually there and I can see it's O.K., THEN I'll have a completely different attitude towards it."

But she assured herself that she would be able to cope with her child. She relied on her image of herself as organized and her belief that motherhood was merely commonsense. Like most of the women, she expected that routine would see her through. She was determined not to "let the baby take you over completely and be in a perpetual muddle. Baby powder all over the place and nappies hanging from the ceiling." Sophie often described motherhood as a job. This image could have several implications. It belonged to her work world where she felt secure, and so might have offered her reassurance. It could also suggest that she saw motherhood as a commonplace thing, devoid of much emotional commitment; and it is no doubt related to her image of motherhood as a learning process. Sophie consistently maintained that she would have to learn how to become a mother. She thought that only "doting" mothers might know what to do by instinct. At eight months she told me, "I don't think it's going to be

by instinct. Perhaps some people are going to be like that - natural mothers. I don't suppose by instinct so much as by the fact that they never stray more than six inches away from the baby if they can help it, so they learn quicker than others.... But I think if you're going about your duties in a normal way, I think it'll just take practice, really."

Despite the fact that she saw motherhood as a learning process, Sophie did not attend the Mothercraft classes, probably because she did not want to be reminded of her pregnancy. Instead, she looked to the hospital confinement to teach her how to care for Jane. She argued that "it's so much better after you've HAD the baby rather than before, when you're not really relating to what's inside you as a baby, and you probably forget everything you're told, anyway." Her experience as a mother strengthened her belief that women learn to be mothers. She felt that she learnt by trial and error, and that it was particularly difficult for women of her type (the wife/worker women) to adapt to motherhood: "Well, it's completely different from anything I'VE ever known, anyway! You know, giving up a responsible job to stay at home and be a housewife and mother. You know, that takes a whole load of adapting to." For Sophie, then, motherhood was an unpleasant break from her former life.

She saw Jane as small and helpless, and repeatedly said that her responsibility for her was frightening (6). She was apprehensive lest Jane should suffer whilst she was learning to take care of her, and during the early days the only way she had of coping with this anxiety was by hoping that Jane would be alright. Initially Sophie tried to follow the books absolutely. Her first attempts at preparing the feeds degenerated into a nightmarish exercise. However, she soon managed to cope with her anxiety. Like most mothers faced with an absence of any body of knowledge, she developed her own operational rules. These centred on her self image ("But then, when you actually think about it, I mean, everybody else has got through, all those millions and millions of mothers"); her image of the baby ("And O.K., you make your mistakes, I suppose, with the babies, but they all live through it. And I think too you can't treat all

babies the same. You've got to remember that the baby IS an individual, not just A BABY which has got to be looked after in a certain way"), and her image of motherhood ("There's no hard and fast rules for looking after a baby, to feeding, bathing and changing a baby - anything. You follow the guide-lines, but it's up to yourself.") These operational rules enabled Sophie to be convinced that she was right in relying on her own judgement and "doing what you think is best."

Operational rules generally focused on the mother's self image, her image of her baby and of motherhood, as Sophie's had done. The image of the baby as an individual, central to Sophie's rules, was fairly common. The image of the baby as resilient or sturdy was also popular. Throughout pregnancy many women had felt apprehensive at the thought of handling a tiny, fragile baby. However, once they were mothers they coped much better if they could convince themselves that their babies were not extremely delicate but could withstand rough treatment. They were able to adopt this image more easily if their babies were big or well-made. These images were discussed more fully in Chapter Nine.

The operational rules Sophie used influenced her attitude towards advice. If there were "no hard and fast rules," it followed that all advice was merely opinion, not proven fact: "And, of course, EVERYBODY'S got their own ideas. You can ask the Health Visitor or the doctor or the nurse, and they all tell you something different - it's what THEY think. It's a matter of personal opinion. There's not one definite answer to anything as regards the baby." However, she did not find this frightening because she believed that "nothing you do is going to harm them," and "after all, the mother's the one that's with them most of the time, so she knows better than anybody else." (It was interesting that Sophie seemed to see "harm" mainly in physical rather than psychological terms.)

Her image of 'mother knows best' was a fairly wide-spread and central one. Its opposite was the image of mother-as-learner, held, for example, by such women as Sheila, Elspeth and Helen. If these learner-mothers also believed that there was a right and a wrong way of rearing babies, they

were the women who would listen very carefully to other people's advice (7).

One of the few girls who did not seem to need a set of operational rules was Maggie. This was probably because to her, motherhood did not mean uncertainty. Instead, after growing up as one of the eldest children in a large family, she felt she knew how to cope. It was also because her daughter was a placid child whom Maggie thought posed few problems.

Sophie did not feel that becoming a mother had altered her images of herself or her baby. She still maintained her rather 'tough', detached attitude: "I don't feel any different from how I've ever felt. You know, as regards motherhood. I think the views I held before, as regards myself, my lack of maternal feelings - I say "lack" in that I'm not over-keen on (never HAVE been over-keen on) babies. I think I've always had a very matter-of-fact view-point of them. And now that I've got one of my own, I don't sit and drool over her, and spend hours hanging over the cot. I mean, I appreciate her, I mean, she's MY baby, and I think she's beautiful, and she might be the ugliest wee thing in the street. But to me, she's mine - and um. But if I ever expected the process of birth to make me into a doting mother, then I was wrong, because it hasn't."

She felt no rush of maternal feeling on the birth of her daughter, nor did she seem dazzled by Jane's perfection in the way that Ruth was. She found difficulty in believing that this was her baby, and she felt extremely relieved that she was "O.K.," but "when I first held her, er no, I didn't, I didn't experience a great rush of maternal feelings. I mean, I thought, oh, this is nice, you know, my baby. But I could look at her objectively and think, well, she's not BAD as babies go, type of thing. But I didn't think, oh, this is great, you know, I'm a mother!" Perhaps Sophie found the prospect of giving free rein to her emotions and 'letting herself go' a rather daunting one. Once again she was placing most of the emphasis upon herself: "I think the actual maternal feeling's just part of it. It's just such an exhilarating feeling to have got

through your nine months and to have had your baby, and to have come through it O.K., and you feel different from those women who HAVEN'T had a baby. Because you've gone through an experience that they haven't so you feel somewhat special." Echoing her description of her feelings after her pregnancy was confirmed, she went on, "And then, of course, you've got all the excitement after the baby's been born of cards and gifts and everything. And everybody is so pleased for you, and all the rest of it. I remember thinking the first night, I kept wakening up throughout the night, and I couldn't believe that it was actually over with. I just felt really great, you know, because I'd really got a baby. I've got a baby daughter after all these months, and she's O.K. And from that point of view it was great, but as far as this maternal thing...."

As Sophie had always decried "maternal" women, perhaps it was not surprising that she denied any rush of maternal feeling at the birth. Instead she preserved her rather detached stance towards Jane. It was significant that during this episode she again placed most of the emphasis upon herself.

Sophie's difficulty in taking on her new role of mother and her lukewarm attitude towards it were probably related to her colourless image of her baby. She never invested Jane with a personality in the way that Ruth did Adam. She spoke of Jane as follows: "I'd never visualized her. I couldn't visualize her before AS a baby. And even just now she's at this stage, I'm thinking of her when she's going to be about a year or two years old. I find it rather nice, you know, to look forward to.... I don't mind looking after her, but I'm looking forward to when she gets older. When she has a bit more personality, whereas just now she just lies around. She's just STARTING to be that bit more interesting. The first time she smiled at me, it brought tears to my eyes. You know, I just felt she's not an inanimate object as such." Sophie never talked in terms of enjoying Jane's babyhood; instead, she was keen for Jane to leave her baby days behind her. It was interesting that Jean, the woman nearest Sophie on the continuum, shared this image of her daughter as still being at the "uninteresting stage."

In common with nearly every other woman, Sophie was adamant that she did not want to breast-feed her baby. She had many reasons: uncertainty ("there's quite a lot that could go wrong in that you may not be producing enough milk, and then you're completely inexperienced as a mother so you don't really know if the baby's getting enough"); the embarrassment of baring her breasts in front of others ("I wouldn't have felt I could have DONE that, sat there and sort of hauled out a breast and started feeding a noisy infant"), and the expectation that breast-feeding would be painful. These reasons were all common ones. Sophie had heard that breast-feeding gave a baby "the best possible start," but she told herself that the most important thing was to hold the baby so that it felt secure and loved. Therefore she felt that Jane was "not really losing anything" by being bottle fed - especially as she believed that mother's milk was not very different from dried milk (8).

Her last reason was more unusual. Sophie saw feeding in terms of her self image and her image of her baby. She explained: "There's just something about it, too. When I was reading about when they get onto mixed feeding at perhaps the age of three months, you know, having their cereals or stewed prunes or whatever, and then having a drink afterwards, just doesn't - The thought of having a completely defenceless little baby LYING there, sucking away and having nothing BUT milk is fine. But then, after they get onto mixed feeding, the thought didn't appeal to me at all. A big baby of about ten months old, breast-feeding, I didn't fancy it at all. I could picture myself with a little infant, a newborn infant. It seems so nice and natural to see a mother and an infant. But once they get to the age where they're starting to pull and grab at things, it just doesn't fit into the picture quite so well. It doesn't have the same sort of romantic ideals, somehow.... Again, not being a madly enthusiastic motherly type, drooling over babies, it just doesn't fit into my picture of motherhood." In short, most of her reasons centred on herself and her reluctance to inconvenience herself in any way.

Once her baby was born, Sophie felt glad that she had decided to bottle

feed, particularly as it meant that Charles could feed Jane when she felt tired. However, she did feel some guilt at not breast-feeding when she read that breast-fed babies do not get fat, and "if it's natural, it's right." She felt jealous of the women in hospital who breast-fed because she thought that they got more attention from the nurses, "and I thought that they had a smug look about them." But she still claimed that, given her images of motherhood, she was not the type of mother who breast-fed (9): "But they all seemed to me to be very sort of calm, contented ladies anyway. They looked the perfect natural mothers, you know, quite the thing, sitting there breast-feeding their babies. However, I think somebody like me would have been even WORSE breast-feeding."

One problem which all women faced when they became mothers was how to react when their babies cried for no apparent reason. (This was discussed in some detail in the last chapter.) Sophie chose to leave Jane to cry. As she tended to see children as schemers, it was consistent that she should see Jane as capable of conscious manipulation - as Sophie said, "We try not to pick her up too much, because then she gets used to it." Her belief that crying was not necessarily a sign that something was wrong encouraged her in this attitude.

Perhaps because she ignored Jane's crying, Sophie was one of the women who soon got into a routine. Jane did not dominate the household; instead Sophie was in complete control. She told me, "After the first couple of days I got things set out in my mind, you know, when I wanted to do things, and I stuck to that.... I feel everything just goes along very smoothly. In most cases the afternoon's my own, with the exception of feeding her."

In marked contrast to more 'maternal' women (that is, those at the other end of the continuum), Sophie felt quite able to go out and enjoy herself and leave Jane with a baby-sitter. Her behaviour here was consistent with her high evaluation of ^{the} wifely role and her reluctance to let motherhood overwhelm her.

Perhaps Sophie's position can be summed up by her final attitude towards

employment. At the beginning of her pregnancy Sophie said that she believed that mothers should "dedicate themselves to their children" for the first five years. However, after Jane had been born, her dissatisfaction with motherhood prompted her to change her mind (10): "I'm finding it quite hard, even yet, you know, just staying in the house all day and doing all these horrible household chores. I miss having a job. I would much rather have something to do AS WELL AS looking after her. If I could have work to do at home, for instance. You know, after working for so long I find it even harder to adapt. To this state." Sophie's desire for a job was so strong that she was already making arrangements to help with her mother's business and to return to her old firm to do part-time work. She told me, "I'm quite looking forward to it, because it's going to get me out."

(2) Ruth: pregnant/maternal.

In pointed contrast to Sophie, Ruth believed that children were an essential part of marriage. Early in her pregnancy she suffered great pain with appendicitis, which she then unwittingly thought was a normal part of pregnancy. Her later reaction to the bitter comments she had felt forced to make about the pain were very revealing of her attitude towards parenthood: "One day I was TERRIBLY ill. I know it's an awful thing to say, but I said, 'Oh, I don't want any more babies. I can't stand it.' But NOW, when I realize that it hasn't been this, I mean, I feel terrible at saying such a thing, because I didn't really feel that way.... I think I was probably a little mentally ill as well. My husband knows I LOVE children, and I mean it would break my heart if I thought I'd gone through married life and NOT had any. Quite honestly, I think if I'd realized in a few years time that I couldn't have any, I would have adopted some." Ruth was thirty when she married and she was keen to have children immediately. She saw children as a natural corollary to getting married which was so obvious that it needed no justification (contrast Sophie's

long and carefully worded explanations.) Ruth felt strongly that all children should be wanted, telling me firmly, "As I say, I'm having this one because we both WANT it."

She knew much more about children than Sophie did, and she always spoke warmly of them. She told me, "I've always loved children, and I worked for a doctor, and I watched his two wee girls grow up. I mean, I nursed them from when they were a week old. And when I left there and got married, well, their eldest one was ten.... And I think I'd as much pride in them as their mother had! To me, I looked on them sometimes as my own. I was very devoted to them - it broke my heart, actually, when I was leaving." Her general images of children were always happy ones, centring on the enjoyable times adults can have with children. Her images stressed play, a thing which Sophie never mentioned. Ruth was atypical in finding babies so irresistible that she felt obliged to spoil them: "I've spoilt everybody's wee ones! My neighbour's, when it cries, I pick it up. She says, 'Oh, don't pick up my baby! Are you going to do that with your own?' I says, 'Oh, no, mine's not going to be spoilt!' But I suppose you do, you're inclined to spoil them."

Sophie was frustrated by being pregnant, but Ruth's attitude was characterized by pride and enjoyment ("to me, it's been a joy.") It was the fulfilment of her dearest hopes; she was "delighted" on learning that she was pregnant, and part of her felt so happy and proud that "I'm shouting to everybody, 'I'm going to have a baby!'" One of the biggest differences between Sophie and Ruth was that whilst Sophie saw her pregnancy very much in terms of herself and her body image, Ruth saw it in terms of her baby. When I asked her why she felt that pregnancy was an experience she was glad she had had, she replied, "Well, the whole thing - I mean, with the baby and all moving, and you're saying to yourself, 'Have I really produced this?' You begin to think it's part of you." Nor did Ruth see the strong similarity between babies and material goods that Sophie had seen. Her imagery was nearer Maggie's in its emphasis upon personal creativity ("my husband and I have made this.") Unlike Sophie, Ruth regarded the baby's very first kick as a stage trans-

-ition; to her, the foetus then became a person, as she described: "From the first day he kicked me - I mean, you really think of them from then on as a wee PERSON. The first three months you don't, because you don't really feel anything. But I think once he's given you his first wee kick, you say that's actually a wee human being in there, that's actually a baby. It's ALIVE."

Because of her past experience with children she expected to know how to care for her baby, but she also expected to be frightened of handling him. Like most women, she equated smallness with vulnerability, and felt worried that she might injure him. She looked to the hospital to give her confidence in handling her child and to provide her with a viable routine, but she found that once she returned home Adam had developed so much that she needed another routine. Sophie soon overcame her initial nervousness with Jane, but Ruth continued to see Adam as vulnerable, and her anxiety manifested itself in her constantly checking that he was still breathing, and in her taking him to the doctor immediately if anything seemed amiss. She described her feelings as follows: "To me it was like learning to drive the car. When I passed my test, the first time I took the car out - I mean, there wasn't somebody sitting beside me, and I felt funny the first day I went out on my own in the car."

Because I thought well, the full responsibility's mine now if anything happens. And I think that this is probably the same feeling that you have when you take your baby home."

Motherhood to Ruth was an interactive learning process, where she learnt from her baby. (In contrast, Sophie did not seem to see her baby as being able to teach her anything.) Ruth explained, "Well, I suppose motherhood does come maybe naturally to you, but there's still a lot you've got to learn. I think there's still a lot you can learn nearly every day from your baby. You LEARN to know when he's really crying, or when he's not. You learn to know if he's got a pain or not. I mean, really, you learn everything with a baby. I don't think you could ever know everything about a baby. I think it comes in stages. You know, as the baby grows and develops, well, you're learning as well."

As she had expected, Ruth found her baby irresistible, and she doted on him. She told me, "Sometimes at night you're sitting there and you're saying, 'You wee rascal, you should be sleeping!' Sort of trying to give him a row. And he looks up at you and he smiles at you, and I mean, your heart just melts and you think, och, how on earth can you be cross with THAT wee thing?" She thought Adam a wonderful piece of creation, and she found him totally absorbing: "I used to look at him in the cot, and I used to look at his wee toes and count them, and his wee hands and all! You just sit there and look at your wain (baby) and you think, I've actually PRODUCED this. There's days when you can't take your eyes off it and you just sit and look at it. And WONDER. It's true what they say, that a baby's God's masterpiece."

In common with several women, she assumed that there was a distinct baby stage and that babies were discrete and different from other creatures. Sophie was looking forward to Jane's growing older and more interesting, but, far from regarding Adam as an 'inanimate object', Ruth already saw him as interesting and something to be enjoyed: "I just like to enjoy my baby now. Maybe people would say I was daft - maybe I spend too much time with him, but you look at it. In another few months he'll be growing up. I mean, they're babies no length of time, so I think you SHOULD enjoy them when they're this age. At the minute he's getting terribly interesting, because he's starting to make noises and gurgle back at me."

It seems that the image a mother has of her baby will affect her behaviour towards him. Because Ruth saw Adam as irresistible and vulnerable, whenever he cried she cuddled him. She said, "No mother will let her baby scream for any length of time. It's TRUE. You'll say you'll let them go, but you'll only listen to a baby crying for so long." Her attitude was strengthened by her belief that a boy could rupture or choke from crying too hard (again note her image of the baby as vulnerable and her strong normative premise that she must not let him be hurt.)

In the early weeks Adam took to crying through the night. After this had

continued for several nights, Ruth took him to the doctor to find out if there was "anything wrong." Her doctor told her there was not. In effect, he presented the wife/worker position (i.e. the one represented here by Sophie.) He described Adam as conscious and calculating, and emphasized Ruth's role as a wife rather than as a mother: "He said, 'Och, what's wrong with you, you're far too fussy about him.' He says, 'Just relax.' And he says, 'That wee rascal knows. You've got him spoilt!' You know, so I realized that too. He says to me, 'There's only one person can sort that baby. If you don't, it'll break up your marriage. Because,' he says, 'You'll start taking it out on your husband because you're not having any sleep.'"

At first Ruth was reluctant to accept this advice as it clashed with her picture of Adam as helpless and irresistible, but eventually she became so exhausted that she found herself forced to ignore Adam. She then adopted the doctor's perspective as a rationalization for ignoring him, and went on to use it as the basis for future behaviour: "I was just so exhausted I passed out on the couch, and that was me for a few hours. So I thought well, there's no point in punishing myself and him and everybody. It's true what the doctor says - it WILL break up my marriage, because I'll start yelling at him because I'm not having any sleep."

Ruth accordingly decided to try a tougher approach with her son: "Well, then, my husband took two days off work, and I said, 'Right, this is it.' And the next night he screamed the whole night. The next morning, once he got up again, he started to yell again. I said, 'Right, you just yell there.' So he yelled for a couple of hours before I even fed him. And I knew it would sound cruel and all that ---- but I says, well, you've got to do it. And it just turned him right away. He started to sleep at night." Thus Ruth was unable to carry on being the doting mother; the price seemed to be her marriage, and that was too heavy a price to pay. She was able to utilize the different self image and baby image suggested by the doctor to effect the transition from being a doting mother to being a tough one, and rescue her marriage and her health.

Perhaps the thing that most marked Ruth out from the rest of the sample was her desire to breast-feed. She had always wanted to breast-feed. She saw it as a relationship: "You probably feel far closer to your baby than somebody who's just maybe bottle feeding and just popping it back in its pram." Later she added, "I feel I'm going to miss something if I don't.... I don't honestly know how to explain it, I just feel it's something I've got to try..I think maybe there's a lot of comfort in breast-feeding a baby. People will tell you it's a nice feeling. And, as the nurse explained to us, it's a lovely feeling to have the baby CLOSE to you." She felt breast-feeding gave the baby "a good start in life," and was good for the mother in that it helped her womb "go back" into place and forced her to relax. And finally, it was "natural," an important theme in Ruth's thinking ("after all, it's nature's way, isn't it, for feeding your young.") Most women thought that breast-feeding would be socially restricting and embarrassing but to Ruth it seemed neither. She had no active social life to spoil, and she did not expect to be embarrassed because "it's nature's way.... I don't think it's anything to be ashamed of." She felt that she would not be exposing much of herself in her maternity 'bra," and anyway, the baby's going to be sitting there, so just how much of you IS going to be showing, to BE embarrassing?"

(11). Alone of all the women she stressed her baby's needs before the embarrassment of herself or her guests: "The baby has to be fed. You're not going to keep your baby screaming for hours just because somebody's sitting chatting to you, you know. I'm just going to say, 'I'm going to feed my baby,' and that's it. And I'll say, 'I breast-feed it, so if you're embarrassed, you'll just have to leave.'" The biggest disappointment of Ruth's pregnancy was that, when the time came, she found she had no milk for Adam.

In conclusion, Ruth's dearest wish was to become a mother, and consequently Adam's birth was regarded as a great and happy fulfilment. At first she accorded so much importance to the baby and her role as mother that she neglected her wifely role ("you're sort of inclined to see to the

baby all the time and forget everybody else.") This was very different from Sophie, who, within a couple of days had the baby so much under her control that "the afternoons are my own." It was also significant that Ruth, unlike Sophie, never mentioned the possibility of returning to work.

(3) Christine: the middle way.

Like Sophie, Christine's reasons for having children were grounded in her marital relationship, but the thrust of her argument was rather different. She said, "Well, I feel you get very selfish, you know, very possessive, money-wise, if you're both working and you see the bank book going up. Or you've got a new car or a new washing machine, things like that. You know, you get sort of over-possessive that way. This is why I wouldn't like to have gone through and not had any children at all. I mean, if we HADN'T had one, we probably would have got selfish. And then that's when I think you end up going your own roads, you know? Because she says, 'Well, I've got my bank book!' They've each got their own bank book, and then, you know, it's hardly worth - to me, I suppose a baby MAKES a marriage, you know."

Thus, like Sophie Christine posited a relationship between her baby and material possessions. She again saw having a family and having a materialistic life style as being in conflict, but she differed from Sophie in that she felt it was necessary to conquer materialism. She was motivated to do this because she believed that otherwise materialism would lead to the destruction of her marriage.

Her attitude towards pregnancy was always rather studiously neutral and dispassionate; it lacked both Ruth's joyful acceptance and Sophie's reluctant endurance. Christine told me that she felt merely "neither one way or the other." This was partly her way of coping with the possibility that there might be something wrong with her child. Perhaps it was for the same reason that she rarely thought about the baby during her pregnancy, and was unable to visualize herself with her child. Her reactions here were nearer to Sophie than to Ruth.

Christine's attitude towards motherhood seemed ambivalent; she told me that she had never been able to see herself as a mother, yet she liked children. Her image of her foetus was unclear. It was neither the inanimate "it" of Sophie, nor the "wee human being," the unmistakable baby of Ruth. Christine described it as follows: "It doesn't really have any form or any looks on it, or anything, you know. You just sort of think of it as a BABY, really! Well, to me all babies are the same, anyway It's a thing, yes. It's not ANYTHING! Not a human being - well, I mean, it is a HUMAN BEING but it's not a boy or a girl, or it's not got red hair or black hair." It seemed to be her ignorance as to physical characteristics which prevented Christine from regarding her foetus as anything very real. Her image fell midway between Sophie's inanimate image and Ruth's vivid realization of a baby.

Christine's attitude towards her appearance veered from one extreme to the other. At the beginning of her pregnancy she was quite happy with the way she looked. However, by the end she had become self-conscious at being big and was upset by jokes about her size.

As Christine had had no experience of children, she did not have any preconceived ideas as to whether she would be a tough or indulgent mother in the way that both Sophie and Ruth had had. She was therefore unable to think her baby through very fully. Because of this, she relied heavily on the Mothercraft classes to tell her what to do: "I wanted to find out as much as I could. Well, to me, not knowing anything, I'd be hopeless. You know, I went right through my pregnancy and I got a baby at the end, and I didn't know if I was doing the right thing. They maybe don't tell you everything, and you don't have to follow those rules, but it sort of gives you a guideline, I feel." Christine also felt that motherhood could be learnt, and she looked to the classes to teach her as she thought that only they could give her the most recent information. Implicit in her thinking at this stage was the assumption that there is a right way to look after a child.

Perhaps because she had been unable to think her baby through, when Kirstine was born Christine's behaviour towards her was an uneasy mix-

ture of the tough and the indulgent. She told me that when Kirstine cried,"I leave her as long as I can. You know,if I'm in the middle of doing washing or ironing or whatever,I leave her crying for maybe five or ten minutes. And let her know that I'm not just going to pick her up when SHE wants picked up. But sometimes I DO,and I'll say,'Oh,it's a shame to let her cry,' you know. And a lot of the time I just pick her up and lay her down there on the couch and she's quite happy."

Christine's behaviour was inconsistent. On the one hand she espoused the authoritarian,tough stance ("I leave her crying.... and let her know that I'm not just going to pick her up when SHE wants picked up") which led her to ignore Kirstine's crying. Her underlying assumption here was that she must not let the baby be in control. On the other hand,she felt sympathetic towards Kirstine ("Oh,it's a shame to let her cry ") and this induced her to drop her tough stance and behave more indulgently towards her. However,Christine still took a middle way out; instead of either ignoring Kirstine,or picking her up and cuddling her in her arms,Christine/^{often}picked Kirstine up only to put her down again on the settee. She rationalized her unpopular indulgent attitude by telling herself that it was "only natural" that Kirstine liked attention: "I mean,THEY'RE sort of human aswell. I wouldn't like it if somebody was picking me up,changing me and putting me back down again! So,I mean,I can understand."

Christine's uncertainty as to how she should treat her daughter was complicated by her belief that her behaviour might alter Kirstine's personality. This was an unusual belief. Christine was frightened of doing this as she thought her baby's placid nature was perfect. She said,"I think that maybe certain things that I do could change her. Make her the exact opposite. Maybe break her temper. You know,if I maybe left her crying too long,or I didn't talk to her enough. I think, you know,I could maybe change her. Which I don't want to do. But probably,you know,with trying to be too hard,and not spoil her. Sort of be the extreme,you know. Instead of picking her up all the time,say,'I'm NOT going to pick her up,and I'm NOT going to give her this,'you know.

'I'm going to put her in her room, and that'll be it.' And forget about her, you know. If I was to do that, I think she'd probably change."

Therefore Christine was faced with a dilemma which she was unable to resolve. She felt she had to steer a path between not spoiling her daughter (and so not lifting her), and not "breaking her temper" (by ignoring her). This unresolved dilemma formed the basis of her inconsistent behaviour.

Her attitude towards control was equally ambiguous. She expected Kirstine to "do what I want her to do, and not what she wants herself" - that is, she expected to control Kirstine. However, her style of motherhood was clearly a baby-centred one ("everything's centred round her, of course.") Routine, that symbol of maternal control, was conspicuously lacking, because, as Christine explained, Kirstine "doesn't THINK in a routine, anyway.... My husband says that you shouldn't make everything round her. But I feel that you can't do anything else BUT centre everything - or, you know, work out everything to suit her. I mean, you've got to consider her feed times and bath times." She seemed to reconcile her desire to be in control with her realization that it was Kirstine who dictated the pace by convincing herself that she had chosen to adopt a policy of baby-centred motherhood ("but I think more or less I do everything to suit myself.") In this was she preserved a semblance of being in control.

Like Sophie, Christine had never considered anything other than bottle feeding, and, again like Sophie, most of her reasons focused on her convenience: "I had my mind made up about that. Didn't want anything to inconvenience me. If it doesn't sort of run with my routine that's it, and breast-feeding would be out of the question. To me, it's too much of a bother. You know, you've got to be back for certain times, and when you're out visiting people it's very awkward as well. So, the bottle's the answer, you know."

However, Christine felt 'maternal' enough to dislike leaving her baby with a sitter. She told me, "Even if I have been out and left her with

somebody, I've felt guilty. Like, I went to the hairdresser's one day and left her with my sister-in-law. And all the time I was there I felt really terrible that I'd left her. I think this is probably just the mother instinct as well."

As far as imbuing Kirstine with personality was concerned, Christine fell midway along the continuum. Her descriptions of Kirstine were of a baby less inanimate than Jane, but also less of a full-blown personality than Adam. For example, Christine believed that she had to learn how to get on with her daughter, which presupposed that Kirstine had at least some personality. On the other hand, she did not expatiate on Kirstine's character as the more 'maternal' women did. (Julie, for example, was beginning to build up a fantasy personality around her baby rather in the way that the parents in the play, A Day in the Death of Joe Egg, built up a persona around their mute retarded child.)

And finally, what was Christine's overall attitude towards motherhood? The earlier sections showed how Ruth was overjoyed at being a mother, whilst Sophie was longing to find work and "get out." Perhaps predictably, Christine was uncertain how she felt. In wondering if she was disillusioned with motherhood she again fell into a middle position between Ruth and Sophie. She said, "I don't know whether I've been disillusioned or not. At the moment I don't really know whether I'm happy or not. I THINK that I am. I THINK it's what I've always wanted. But I can't really make my mind up one way or the other. I can't say my true feelings, because I don't know them." Christine could be described as vacillating between the wife/worker self and the maternal self, uncertain as to which she preferred: "My husband'll say, 'You've got everything you wanted. What more could you want?' But then I think to myself, IS it what I wanted? You know. I'm quite happy now that I've got it. I mean, I THINK I am. But I don't know." She still found the wife/worker image attractive: "You think your

friends are going out and that, and are able just to walk out. And you are just stuck there, you can't go out. And that's what I feel with the baby. Well, I'm not really RESENTFUL.... I think, actually, really what's wrong with me is that my sister's going about with a crowd of girls, and they're all going about enjoying themselves. And one of the girls is actually away from her husband, and she's got a little boy. And I don't know whether maybe this has sort of triggered it off. Made me feel discontented seeing other people enjoying themselves." Her sister's group, then, provided a vivid illustration of the alternative life style. However, Christine was uncertain whether that sort of enjoyment was what she wanted: "But I don't really FEEL I want to go out and enjoy myself. I've enjoyed my life, and I don't think I would WANT to go out with them every week, go to the dancing and go out for a drink."

Conclusion.

I have postulated that women's reactions to motherhood can be expressed as a continuum. As the two preceding sections showed, there are two polar self images, both with their own ideologies. Women at the ends of the continuum were able to follow their ideologies consistently. Christine was an example of someone who fell in the middle of the continuum (for example, see her attitude towards pregnancy, her body image and her image of her foetus.) One would expect her to have elements of both ideologies and as a result to behave in an inconsistent or ambivalent way.

This was certainly true of Christine. For example, she was unsure whether to be a tough mother (like Sophie) and leave the baby to its own devices, or an indulgent one (like Ruth set out to be) and pay the baby a lot of attention. Her behaviour therefore contained traces of both approaches and lapsed into inconsistency. Her attitude towards motherhood was equally inconsistent. At one moment she took up the 'maternal' position, saying that in Kirstine she had everything she had always wanted. At the next, however, she veered more towards Sophie

as she wondered if she might prefer an unrestricted social life. The fact that Christine fell into a middle position and reacted in this way is evidence for the existence of the continuum.

Summary.

This section describes some of the main differences between the wife/worker women and the pregnant/maternal women as illustrated by Sophie and Ruth.

A major difference between Sophie and Ruth was that Ruth saw pregnancy and motherhood in terms of her baby, whereas Sophie saw them in terms of herself. This was manifest in the discussion of the three primary variables, body image, self image and image of the baby.

Their body images were described in Chapter Six. Briefly, Ruth was proud of her pregnant appearance, but Sophie was keen to retain her slim, attractive figure for as long as she could.

Ruth had always wanted to be a mother and could easily visualize herself as one. Her happiness was grounded far more in being a mother than in being an attractive woman. She was so content looking after Adam that she had no thoughts of finding a job. Sophie's position was exactly the opposite of this. She felt ambivalent about becoming a mother and could not visualize herself with a baby. She was frightened that motherhood might engulf her. When motherhood did come, Sophie found it boring - so much so that she was trying to find an outside job.

The third important area of difference was their images of their baby. From the first time it kicked, Ruth thought of her foetus as a live baby. Because of this she was able to form a relationship with it whilst it was still in the womb. Once Adam was born, Ruth found him irresistible, absorbing and miraculous. She also saw him as fragile and vulnerable, and was preoccupied by her fear of hurting him. Sophie, however, never saw her foetus as a person; to her it was always a thing. Consequently she did not seem to have formed any relationship with it before it was born. Once Jane was born, Sophie

found her uninteresting. She soon discarded the image of babies as vulnerable and came to believe that babies were resilient and therefore difficult to harm.

Ruth and Sophie went on to develop different ideologies, or coherent bodies of thinking based on their position on the continuum, which were grounded in their set of images. Out of her 'maternal' self image and her image of Adam as irresistible and vulnerable, Ruth developed an indulgent ideology as a mother. Sophie, with her wife/worker self image and her picture of Jane as resilient, manipulative and uninteresting, developed a tougher ideology. These ideologies had behavioural consequences in terms of how the women reacted towards their babies, particularly when the children cried for no obvious reason: Ruth (at least initially) always picked Adam up, but Sophie tended to leave Jane alone.

Ruth and Sophie also differed on several secondary variables. For example, they had different images of marriage and parenthood, Ruth seeing parenthood as an inevitable corollary of marriage, and Sophie regarding them as two distinct states, with marriage as the more important. Their general images of children were very dissimilar. Ruth enjoyed being with children, found them absorbing and knew a lot about them. Sophie had had much less contact with children. She saw them as sly and attention-seeking and felt that they were often competing with adults for the lime-light. She lacked Ruth's tolerant attitude towards them, feeling instead that they should "know their place." The women also had differing reactions to being pregnant. Ruth enjoyed her nine months and welcomed pregnancy as an experience in itself, but Sophie disliked being pregnant because it restricted her social life.

The choice of feeding could be seen as a behavioural consequence of the types of women Ruth and Sophie were. As earlier sections showed, Ruth had developed an ideology which centred on the baby, whereas Sophie had developed one which centred on herself. Therefore, as Ruth

saw breast-feeding as a method which offered her a more intimate relationship with her baby, she wanted to breast-feed. Sophie, however, saw breast-feeding primarily in terms of its inconvenience to her, and so she chose to bottle feed.

Despite her greater experience of children, it was Ruth who found the early days of motherhood more taxing. This was largely because her indulgent ideology led her to pick Adam up every time he cried. She was therefore never able to get into a routine, but was always in Adam's control. After a few weeks this became so wearing that she found it impossible to continue in this way and so she rather guiltily changed her ideology towards Sophie's tougher approach and left Adam to cry on his own.

Conclusion.

My data shows that the women's reactions to pregnancy and motherhood formed a continuum. At one end were the women who valued their wife/worker selves and their attractive appearance. They are illustrated here by Sophie. At the opposite end were the women who valued their pregnant/maternal selves, and who were proud of their pregnant shape. Ruth is an example of these women. Christine is an example of a woman in the centre of the continuum. Her reactions were typified by uncertainty and inconsistency. These women differed on a number of key images. Out of these images, they developed their own ideologies and these in turn had behavioural consequences.

The continuum is significant in that it can help predict behavioural consequences. The mother's image of her baby has already been shown to be an important indicator as to whether she might batter her child. Ounsted (12) has found that if, through complications or prematurity, the baby and mother are not in close contact for some weeks, battering is more likely to occur, as then the mother has had time to build up "a fantasy baby in her head," a near-perfect child which is nothing like the one finally handed over to her. My research takes this further. I have shown that a whole series of images, some of which are

formed well before the baby is born, are significant in determining how a mother will react to her child. Principal among these are self image, body image and, as Ounsted has demonstrated, the mother's image of her baby.

CHAPTER TWELVE: THE MEANING OF THE TRANSITION TO MOTHERHOOD

Introduction.

Sociologists have described the transition to parenthood as one of the major status passages in modern industrial society. This chapter looks at the meanings the women gave to the transition. When asked directly, a surprising number of women told me that becoming a mother had had little effect on them. However, as they went on talking, it appeared that they had noticed some significant changes. The main ones occurred in the following inter-related areas: their life-style, identity, relationships and their perceptions of the meaning of life.

The Women's Perceptions of the Transition.

Some girls told me that when they had their babies they "felt different" from childless women. As Sophie said, "You feel different from those women who haven't had a baby, because you've gone through an experience that they haven't, so you feel somewhat special."

"Feeling different" could mean many things. Some women found that once they began looking after their baby, the new role of mother took precedence over the old roles of house-wife and wife. For example, Anna told me, "My husband said to me last night, 'I've no clean socks.' I said, 'Well, you should have told me.' I'd never have DREAMED of saying that to my husband ('you should have told me') but, I mean, you canna help it now. He HAS got to tell me everything he needs done. I've no got time to go looking to make sure his cupboard's stocked with clean shirts, and his drawers are stocked with clean socks. I know you should, but I've just no got the time. Maybe when the bairn's older - I keep saying that! (starts to laugh) I'll probably be saying that when the bairn's fifteen!"

Housework often suffered: "But you do realize, of course, that you canna just do as much as you would like. Like, normally, I would have hoovered in here, and went round all the corners dusting. I just don't do that any more. I just do over the top, and then at the weekend, when Paul's off, I'll

do it properly. I'm no as fussy now as what I used to be."

And Lynne felt she had to put her duties as a mother before those as a wife: "Rab and I used to lie on the settee and cuddle into each other and watch the telly. I mean, you can't do that now, really. You can for a wee while, and then Adam may start, and you've got to jump up." In earlier interviews Jean had shown how central her attractive appearance was to her marital relationship, but now she confided, "I've really let myself go. Like, I've never bothered to get my - I canna get my clothes on. My dresses and everything are still far too tight. And I get that I canna be bothered getting dressed or anything.... See, I never have TIME to do anything to myself (1). I mean, I just canna say I'll go to the hairdresser's, because I canna, because I've nobody to watch HER. And I canna do my hair myself, I've never been able to. So there was THAT, and you've no got time to put make-up on during the day because you're running up and down and you're doing this and you're doing that."

In addition, some women felt different in themselves. For instance, Elspeth felt much more confident once she had become a mother: "I feel much more confident now. That sounds daft after saying I've been panicking, but in MYSELF I feel - not necessarily to do with her - I feel much more confident about doing anything. Going anywhere. Like, for example, I don't know if you know, but we're a mixed marriage, in religion. And we decided the baby would be brought up a Catholic, like Douglas. And with his exams and everything, he couldn't get to the priest to arrange it, and he wanted the baby christened soon. And so I thought, well, I'LL go. And I never would have done that before. I never would have VENTURED to have done anything like that before. It wasn't until afterwards I thought oh, I wouldn't have done that before. What's wrong with me?!"

Le Masters (2) has suggested that "parenthood (not marriage) marks the final transition to maturity and adult responsibility in our culture. Thus the arrival of the first child forces the young married couple to take the last painful step into the adult world." Dyer (3) found that 87% of the wives in his study felt that parenthood had been a maturing experience, whilst Blood and Wolfe (4) reported that parenthood helped

couples settle down and become more responsible, less self-centred and more considerate. I did not ask the women specifically about this, but four of them spontaneously mentioned that they felt more mature now (Sheena, Judith, Kathleen and Gina). For example, Sheena told me, "I feel more responsible now. Whereas before I used to go out with June when she had her first baby. And she wouldn't drink, and she'd always be saying, 'I wonder how the wee one is?' And at the time I used to think, 'T! For goodness sake, can she no ENJOY herself?' I used to think, 'That's terrible. You've got somebody watching him.' But I can understand that now. Because if I was going out for a drink I'd just take so many and that's it. In case maybe anything happened to him during the night and maybe we weren't capable. I can understand that now. Your life just seems to revolve round them now, whereas before it was the two of you - you know, just Andy and I. But now it revolves round him. I think it's made me a bit more grown up, anyway."

Five other women implied that, at least in some respects, they had become more mature. I have already shown how Elspeth felt more confident within herself. In addition, Pat felt she was better tempered, and Wendy, who had previously seen herself as very "undomesticated," found herself more caring towards her baby than she had thought possible. Maggie felt much more sympathetic towards her mother now that she realized what work was involved, whilst Brenda could now discuss sexual matters freely with her mother for the first time.

A few girls saw a relationship between maturing and feeling older. Jean, for instance, was equally conscious of her new responsibilities, but in a more negative way. As she had conceived shortly after marriage, motherhood and pregnancy for her entailed a dramatic change: "See when I was pregnant, I hated pop music for some reason. (I've begun to like it again now.) But I hated pop music, and I hated watching folks dancing on "Top of the Pops." I was right envious. And I felt as if I was a hell of a lot older than I am. And yet I'm no, I'm only twenty two. But I feel a hell of a lot older than that. I feel about forty. I think it's all the responsibility. Because I used to have a right carefree life - out with

different fellows every night and away enjoying myself. And now I'm stuck in this house. I never see nobody for weeks and weeks. And I never get any young company. And it makes you feel old. I feel like I'm ancient, because I'm aye with old company " (5).

Wendy had difficulty in resuming her social life because she found that when she went out, she felt disconcertingly older than the rest of the company, as she explained: "When Scott and I went out for a drink, well, I felt everybody was - I felt a lot OLDER than everybody else, and I don't really suppose I LOOKED a lot older. I said to Scott, 'Oh, I feel like an old granny,' I says, 'It's awful.' I felt APART." She decided this was because she had been "out of circulation" for so long, because, as she had grown so big towards the end of her pregnancy she had had virtually no social life for several months.

As well as feeling "older" and "apart," Wendy also felt "as if everybody was looking at me and saying, 'Oh, she's just had a baby.'" In effect, she felt stigmatized. Rapoport and Rapoport (6) have described how a role change can involve a change in self image and reference group: "As an individual's social role changes, his image of himself is affected, the ways in which he is expected by others to behave are affected, and his legitimate expectations with regard to the behaviour of others change. The norms, standards and groups to which the individual refers his own behaviour changes as his roles change, and he may grow and develop under the impact of these new stimuli, or he may find them burdensome and distressing."

Wendy went on to tell me that she felt different from her childless friends. She said, "When I started going out with Carol again for a wee chat and a drink, I felt a wee bit different, you know. I didn't feel the same as her any longer.... You see, she's single. She's working and everything." Wendy found herself talking about different things now: "I think, too, it's awful difficult (I found it when I went to visit Anne, actually, the one who has the baby) to have a conversation - although not that you really want to, but you can't have a conversation with any-

one without talking about them. And they TEND (laughs) to take over the conversation."

This tendency to discuss children almost exclusively reunited Wendy with her former friends who were already mothers: "Most of my friends at this time, they all seem to be about the same stage. Just either had a child, or pregnant just now. So it's not really as if my friendships are going to alter, because they're all going to be mothers as well. Because one of my girlfriends had a baby boy four years ago, and our friendship - well, we never broke off our friendship, but it took on a different aspect, and we didn't feel as close. You sort of lost something in your friendship. But since I became pregnant we've become a lot more friendly again. Not so much more FRIENDLY, but thinking more on the same lines, I would say. You know, with more interest in common than before. Because it's difficult if your friend DOESN'T have a family. I mean, I found that when I was first pregnant. I've got a girlfriend, and I found that when I was in her company I thought, 'Gosh, am I talking too much about being pregnant?' You know, she'll be sick - sick listening to me. She'll be fed up hearing about babies and what have you. But now that we're mostly the same.... (tails off)!"

Perhaps the biggest change that the women faced was the transition from a life-style which was largely spontaneous, self-centred and active to one which was much lonelier, where evenings had to be planned out in advance and became precious because of their rarity. (As Anna put it, "A wee night out at the pictures just isn't a wee night out any more! It's a big THING now. You look forward to it, and you get all dressed up as if you were going to meet the Queen.")

It was perhaps understandable that nights out became an important issue. Helen for one feared that the baby would prevent her going out with her husband. She described how she fought against this: "As Bob says, you only really have them till they start to go to school. Then that's it, you start to lose them after that. They get married, and that's them out of the house again, sort of thing, and you're back together again almost, as you were before you had a family. This is why I like to try if poss-

-ible - Saturday was always the night we went out, and I try my hardest to get organized for a Saturday night, because you find - well, HEAR lots of husbands start to make their own routine about going out certain nights because the wife can't go out. They've got a family, and they can't get baby-sitters, so the HUSBANDS just go out.... So I don't want that kind of habit to start, so I said to Bob, "Whatever happens, we're GOING to go out on Saturday night. And if we can't get out, you're not going out on your own."

Sometimes a night out could become a mile-stone in a new mother's adjustment to her role. Elspeth, for example, became frantic to get out "and forget about everything." She was particularly keen to attend a party for her husband's class, and this party marked the mile-stone: "After that party I felt fine. But I was getting a bit fed up, and thinking, oh, God, I'm always going to be like this, I'm never going to get out. And then that was it. I was alright once we'd been." However, nights out could be infrequent, because, as earlier chapters have shown, some women were loath to leave their babies.

The women's free routine with their babies did not help towards an active social life. Perhaps because they believed that they should have complete control over their children, most of them expected their babies to fit in with their routine. However, once the babies were there, they tended to find that it was more a case of their fitting in with their babies' routine, which meant their feeding times. One result of this was that the women were left unable to plan anything; everything decided upon when the baby wanted its feed.

The transition to motherhood could also bring about subtle changes in the relationships the women had with several significant others. Many of them had wondered if having a baby would affect their relationship with their husbands. On the whole, there seemed to be a tendency for the strongly 'maternal' women to feel closer to their husbands once they became parents, and for the less 'maternal' women to see their babies as potentially disruptive forces ("babies shouldn't come between you").

The girls' relationship with their mothers sometimes changed (7). For example, Maggie felt much more sympathetic towards her mother over the work she had to do: "Well, it's funny, you know, being a mother instead of HAVING a mother. Before you always depended on your mother. Well, now I realize when you're married and you've got a house and you've got a baby of your own, the work that my OWN mother had to do. I mean, she had seven of us, and I've only got ONE. And the work that's involved in one! You know, you sort of feel a lot more for your mother and try to help her a lot more now. Because before you used to think nothing of just dumping your washing and getting your mother to do it. And you never thought at the time there was nine in the house to get washed and ironed for. You never realized what a strain it was on your own mother."

Maggie also found that she now reacted differently towards children. She said, "Your feelings are all different. Like, you sort of understand other children better as well, now that you have a child of your own. Because I used to like to have a child for a wee while, but be able to hand it back. But now, with having her, with my niece or my nephew or that, if any of them cry, you sort of want to try and help them and comfort them. Now you can comfort them because you know what it's like with your own."

Brenda's world widened once Tony was born. She felt more able to go out once she had the baby for company, and she found that people struck up conversations with her about him. Brenda found these encounters difficult because she was not skilful at making conversation. However, this seemed to be a time-honoured way of making friends. A friend of Helen's told me that she was still friendly with women she had met twenty years ago whilst she was out pushing her pram.

Children could alter the marital relationship by giving the couple a new focus in life (8). Maggie felt that she and Jeff were growing closer together because Diane provided them with a mutual interest: "You're

both sort of sharing what she's doing together. Whereas before, I mean, we went out and we enjoyed ourselves, and when we came back in, we had nothing really to interest us. But now we've got her to interest us, and it keeps us watching for everything different that she's doing and that, you know, taking an interest in HER. So we're coming closer together, you know.... Whereas before, you never really had an awful lot to talk about. Just your social life and your work and things like that. Just everyday things like married couples normally talk about. But when you've got a baby, everything seems so different. You've got different interests, and you're both trying to look for what she's doing different." Pat implied that Anita gave them a purpose in life (9). She said, "It just makes a house. It gives you something to work for, really. You're not just working for the house and for yourself."

And finally, Anna summed up what becoming a mother meant for her: "We ALWAYS wanted kids, but it never seemed to happen, and it happened to everybody else whilst we were married the longest. But, I don't know, when it HAPPENED, you know, we were both that taken aback that it DID happen when we didn't think it would. We had started making plans for doing this, and going abroad next year, and things like that - and then you're pregnant, and that's the end of everything. But it's the beginning, then, of a family life."

PART III : CONCLUSIONS

Uncertainty pervades first pregnancy. The women were uncertain both about the physical nature of pregnancy itself and the procedure it involved, such as booking the bed, ante-natal clinics and internal examinations.

During pregnancy, which involves two human beings living in the same body and a major change in the woman's appearance, it was not surprising that questions of identity and body image should loom large. As our society does not lay down explicit guide-lines as to how pregnant women should behave, it took the women time to work out for themselves what they felt their identity had become. One aspect of identity which underwent change was their sexual self image. As pregnancy progressed they gradually divested themselves of their sexuality, and this in turn had consequences for their behaviour. For example, some women were prompted to redefine men's sexual attention, or to misrepresent themselves in front of men and 'pass' as not pregnant. Body image carried a variety of meanings for different women, and reactions to it were equally various. It could, for instance, be welcomed as a means of establishing them in their new identity, or mourned as the loss of their former, attractive selves. It seems that there is a correlation between a woman's attitude towards her body image and her reaction towards motherhood. If she is eager to become a mother, she probably welcomes her new appearance; alternatively, if she is more reluctant to see herself as a mother, she probably dislikes her new shape. But however they reacted to their appearance, all the women seemed to find it helpful to have a number of coping mechanisms upon which they could draw in order to reassure themselves that they looked presentable.

The reasons why some women found parts of the transition embarrassing stemmed directly from their perceptions of their identity and their body image. They felt embarrassed when, still thinking of themselves in sexual terms, they had to reveal intimate parts of their bodies in front of male doctors. They regarded the Booking Clinic as

a crisis point precisely because it was the first time that this happened. Images of the examination, the doctor and herself all played an important part in determining whether a woman felt embarrassed. Perhaps one of the most interesting examinations was the post-natal. Here the women fell sharply into two groups: those who were embarrassed and those who were not. It seemed that which group a woman fell into was determined at least in part by the type of coping mechanisms she had used in the past. If these had been predominantly doctor-centred, she would probably remain unembarrassed. If, however, they had been largely baby-centred, she was more likely to feel embarrassed as her raison d'être for the encounter had disappeared.

The women felt that crying in the face of pain was embarrassing. As they expected the birth to be very painful, they spent a lot of time during pregnancy working out mechanisms to help them cope with it.

In pre-industrial societies women turned to religious relics and magical stones; my women turned to drugs and modern medical techniques. By thinking about her child during pregnancy a woman has the opportunity of beginning to develop a relationship with it. Images of the baby at this stage were manifold. Some of the more common preoccupations were the baby's health and well-being (would it be alright?), and its sex (what would it be?) This was an area where magic and superstition provided possible ways of offering reassurance and even answers. Sex preferences were revealing of the women's images of baby boys and girls.

Once the baby arrived, the women found themselves faced with the common problem of what to do when he cried. Most of them assumed that newly born babies were capable of conscious actions, and often cried solely in order to receive attention. Too much attention, however, was thought to spoil a baby. It was therefore imperative that the mothers should believe that they could distinguish between the baby's different cries, and any woman who returned home from hospital with a 'cry baby' faced the tantalizing dilemma of deciding how she should react. Of all the coping mechanisms to which they resorted in an attempt to pacify their

babies the most popular was the use of solids.

Images and experiences of motherhood varied widely. Perhaps this can best be expressed as a continuum; at one end were the women who were eager to become mothers and who took pride in their pregnant appearance, and at the other were the girls who were less enthusiastic about motherhood and more concerned about losing their independence and their attractive figures. The perceptions of each group differed on a number of points. Principal among these were their self image, their body image and their image of their foetus.

There were several ways in which the transition to parenthood seemed to have affected the women. Most of them felt that it restricted their social life. It also seemed to involve changes in the way they saw themselves, their relationship with others and in the meaning they gave to life. Indeed, for some couples the baby had become the constant topic of conversation, the focus of all their hopes and fears.

This study points to the need for certain administrative changes in the maternity services. These are discussed in the final chapter.

Introduction

This thesis has described how a small group of women experienced pregnancy and has attempted to draw together their experiences using a sociological perspective. However, it is clear, particularly from the material discussed in the chapters on uncertainty, embarrassment and coping with the baby, that the women were often disturbed by the way the hospital services were organized at the time when the study was undertaken. In particular, they were often greatly embarrassed by the internal examinations; they found it difficult to decide what was 'normal' during pregnancy and during the early days of motherhood; and they were often perplexed by the reticence of the medical staff to volunteer information. For one or more of these reasons the women felt that they had experienced a more difficult pregnancy than they might otherwise have done. This therefore raises the question of whether or not current hospital procedure provides the most efficient and effective use of resources, and the best care - in the widest sense - of maternity patients. The comments offered by my women lead me to believe that it does not. I am therefore setting out in this chapter some thoughts on how the maternity services might be improved. It is important to bear in mind that I did not use a statistically based methodology and that the results do not necessarily have a broad application in every detail. Nevertheless, these comments were made to some degree by most of the women I interviewed. They are therefore discussed here so that staff in the maternity services can consider if they are appropriate to their particular circumstances. For the long term development of the Health Service it is extremely important, in my view, that future research should be undertaken to examine these criticisms more fully, using a methodology that will

have a detailed general application.

After this study was completed, the Health Services in Scotland underwent reorganization (1). However, this is unlikely to have affected the criticisms set out below. The reorganization was of the overall structure of the service; but my women were more concerned about the interaction between the patient and the medical staff.

The internal examinations

Women were usually given internal examinations at the Booking Clinic, during labour and their stay in hospital and six weeks after their delivery. It was also the practice of one hospital to give an internal examination about a month before the expected date of delivery in order to monitor the foetus' development.

As Chapter Seven showed, those women who had never been examined internally before felt extremely embarrassed by some of these examinations. The one they found most embarrassing was the examination at the Booking Clinic. There are three points here. These women experienced considerable stress at being examined by a young male doctor. The examination therefore became more painful for the women and more difficult for the doctor to conduct since the women felt too anxious to relax properly. After hearing discouraging rumours about these examinations some of the girls found it hard to summon up the courage to keep their appointment at the Clinic. It is probable that this examination and the mythology surrounding it is responsible for fewer lower social class women attending the Booking Clinic or going on to make as full use of the ante-natal services as women from higher social classes (2).

Because internal examinations form an important part of obstetric care, doctors, hospitals and medical schools should give considerable thought to how they should be conducted. The Royal Commission on Medical Educ-

-ation (3) said: "All students should be taught to recognize the effect of their own behaviour upon other people and should be given some understanding of social skills, some help in developing them and some practice in their application; all this would be directly useful in the clinical part of their course as well as in later life." My research suggests that women would be less embarrassed during their obstetric care if the doctors behaved in the following way. They should refuse to allow other medical staff to watch an internal examination of any kind if it is a patient's first experience of such an examination. If she has been examined internally before, the staff should make a point of asking her permission before allowing others to watch. The most appropriate manner for the doctor to adopt depends partly on his perception of the woman's personality. There also seems to be a class difference here. My women appreciated affable, chatty doctors who joked with them and by their behaviour implicitly emphasized the ordinariness of what they were doing and thereby gave the women a coping mechanism for the examination. But Freidson (4) has suggested that middle class patients prefer doctors who behave as colleagues and who impart fairly elaborate and technical information. Doctors should certainly always explain the reason for these examinations. Those women who could see a clear and important reason for being examined were less likely to perceive the examinations in a sexual and therefore embarrassing light. The doctor should always be at pains not to stress his sexual identity. For example, he should try not to flirt with other women in front of his patients as one doctor did in front of Gina immediately before examining her. Once a woman sees her doctor primarily as a male, rather than as a professional, it is difficult for her to perceive the examination in anything but sexual, and therefore embarrassing, terms.

Chapter Seven described how after the relatively unembarrassed periods of the birth and the few days in hospital, embarrassment resurfaced at the post-natal examination. The women fell into two distinct groups in this respect: those who were embarrassed and those who were not. Which group they fell into largely depended upon whether they had used baby-centred or doctor-centred coping mechanisms during their pregnancy. Those who had used doctor mechanisms were able to go on using them and thus remain unembarrassed. However, those who had used baby mechanisms were left with a void. These mechanisms were clearly no longer possible once the baby had been born, and so the girls' attention was left to fix on the doctor and what he was doing. It would therefore help these women conquer their embarrassment and anxiety (and make them easier patients) if the doctor could casually provide them with some doctor-centred mechanisms which would enable them to set the examination outside the sexual context (e.g. "I'm only a doctor doing my job / I do this all day/ I've seen hundreds of women like you before.")

Throughout this entire period all the staff should be aware of the importance many women attach to their appearance. Then such episodes as Anna's misery at being teased by a jocular nurse that after the birth of her baby she was still a stone over-weight could be avoided.

Changes in medical education would certainly help medical staff. As Barnes (5) has pointed out, medical training begins among books and skeletons, not among people, and it is interesting to speculate how male gynaecologists perceive women (6). In a recent review of gynaecological text books used in American medical schools, Scully and Dart (7) have shown that traditional views of female sexuality and personality are presented with no acknowledgement of the profound effect recent thought and research findings have had on them. Consequently, the picture of

women that emerges from these text books is the traditional one of creatures who are "anatomically destined to reproduce, nurture and keep their husbands happy." It would benefit both patients and doctors if medical training offered some insight into patients' perceptions and emotional needs (8). Medical training should include some sociological and psychological analyses of pregnancy from a female perspective. The Royal Commission on Medical Education recommended that training should include the teaching of the behavioural sciences. However, this Report has never been generally implemented. On the basis of my work it is clear that the Commission's recommendations on broadening the basis of medical education should be introduced as quickly as possible.

Changes in hospital practice could also reduce the patients' embarrassment. For example, I have already shown that a major reason why the women were embarrassed by internal examinations was because the doctors who gave them were young men. This would be avoided if these sessions (particularly the Booking Clinic and the post-natal) were taken by local G.Ps or older doctors. Some G.Ps already give some women their post-natal examination, and the women they examined seemed much less anxious about it than those girls who attended the hospital. The current promotion structure in the hospital works to the patients' disadvantage here because older doctors are generally promoted away from this type of work. More women doctors might also ease the situation, but it is worth remembering that one or two of my women disliked being examined internally by a female doctor as they thought it held overtones of lesbianism.

The hospitals could do more to help the women cope with their embarrassment at the birth, particularly through the Relaxation Classes. These were helpful in providing girls with coping mechanisms for pain ; they

could also be used to provide mechanisms for embarrassment. For example, they could emphasize that most women do not find the delivery embarrassing because there is so much happening to distract them, and that the medical staff regard birth as an ordinary event which they have seen many times before.

The preparations for birth could certainly be made less embarrassing. The shaving, for instance, could probably be abandoned⁽⁹⁾, particularly since Burchell (10) has reported that in his hospital more than 7600 women have been delivered without having been shaved and with no increase in post-partum complications (as measured by the incidence of fever, endometritis or readmission to hospital) - the usual argument against not shaving women. Instead, wiping the vulva with gauze sponges to remove any mucus or blood was quite sufficient.

It would also be helpful if pregnant women were warned before labour began that when their waters broke they would probably go on dribbling water for some time. The women would then be less likely to feel ashamed at having, in their eyes, committed the childish sin of wetting the bed.

Distinguishing Normality.

During Pregnancy.

Uncertainty was most acute in the early months of pregnancy, probably because the women were then less likely to come into contact with people who could give them information about pregnancy. This was partly because their ante-natal appointments were only monthly at that time, and partly because in most cases the Relaxation Classes and the Mothercraft Classes had still to start. Their own mothers were able to give them some information, but the help they could give was limited by the women's belief

that their knowledge was out of date. Friends who had had babies recently could be much more useful, but not every woman was lucky enough to have regular contact with such friends. There was therefore a vacuum here which the maternity services should try to fill.

Schofield (11) has pointed out that for almost two thousand years there have been taboos in most Western cultures forbidding conversation about sexual matters. Even the description of simple anatomical details were felt to be immodest and distasteful. The sexual act was considered dirty and children had to be safe-guarded from unclean thought. Against such a background any discussion of pregnancy at school would constitute a valuable step. Some schools already do this; all schools should be encouraged to follow their example (12). I do not propose to discuss the details of how this could be organized, but such discussion could perhaps form part of the general sex education syllabus, and should certainly discuss parenthood and its implications. These lessons should also examine the biological aspect of pregnancy (what happens inside the body), and how women feel during the nine months. It would also be helpful if the lessons could describe all the signs of pregnancy, and advise the girls when to seek confirmation of pregnancy.

All the women found the booklets which were distributed at the Booking Clinic useful. They described in general terms how the women should feel at various stages of their pregnancy, and what they should and should not do. But, because they needed information quickly, and they did not attend the Booking Clinic until their third or fourth month, it would be a considerable improvement if something similar were available at the G.P.'s surgery immediately after pregnancy is confirmed (13). The Relaxation Classes and the Mothercraft Classes were another valuable source of information. They were run by the individual hospitals. The

Relaxation Classes concentrated on what happens during labour and how women can best cope with it. The Mothercraft Classes covered such subjects as how conception occurs, what clothes women should buy for themselves and the baby, and how one bathes a baby. Each class was generally made up of four to six sessions which were held sometime after the women had been to the Booking Clinic. However, although these classes were useful, it would be worth considering supplementing them with one more session held much earlier than the others, perhaps at the time of the Booking Clinic. At that stage my women would have liked to have had some idea of which symptoms were common in pregnancy (and therefore not a cause for alarm), behaviour during pregnancy (and in particular whether one should adopt the sick role), how one can recognize foetal movement and the medical procedure throughout the process. Ideally, this should be a fairly small, informal affair, given by women who have recently born children themselves, since this might give the newly pregnant women confidence to broach subjects which were worrying them but they thought might sound trivial to others.

The Relaxation Classes helped many women who attended them, but unfortunately the women who were most afraid of labour and who therefore would probably have benefited most from them, often did not attend. Some women never would, because their way of coping with the prospect of birth was to repress it. But many more women could be persuaded to attend, I feel, if the classes were presented in a constructive way. I felt that Ruth's experience was significant here. She told me that a woman at her doctor's surgery had invited her to join the classes. This lady had explained to her in great detail what the Classes entailed and how they could help her. Consequently Ruth came away with a clear idea of their relevance and was extremely enthusiastic about attending. But Lynne's

experience was very different. She said she knew nothing about the classes. She had never been asked to go, and so she did not attend. Women who are afraid of labour would be more likely to attend if they were approached in the way that Ruth had been. At least then the myth would be dispelled that Relaxation Classes are little more than an extension of school gymnastic lessons.

In conclusion, women need information early in their pregnancy. I have suggested several ways of getting it across to them: by teaching in school, by distributing booklets when the pregnancy is confirmed, by holding one early class at the hospital and by presenting the Relaxation Classes in a more positive way. The Department of Health and Social Security needs to consider this problem very carefully and, in particular, it should mount broader studies of the anxieties and fears felt by pregnant women and of the effectiveness of different methods of presenting the information that they want and need.

During the Early Days of Motherhood.

Most women felt very unsure of themselves as mothers during their first few weeks. They wondered if they were looking after their baby in the 'right' way and some of them openly described themselves as "learners." Literature on child care abounds. It is an area which is susceptible to the vagaries of fashion, swinging over the years from the extreme of Truby King (14) to that of Spock (15).

The women I interviewed, however, were largely unaware of the existence of this literature. Their ideas of child care were grounded in different premises and developed into different perspectives relying mainly on emotion, hear-say and superstition. There was therefore a wide gap between their various perspectives and the rational, 'scientific' approach

espoused by the medical profession. Hubert's research among working class women in London (16) drew similar conclusions, and Freidson (17) maintains that such a clash of perspectives between the professional and the client is inevitable. He argued that the practitioner, looking from his professional vantage point, preserves his detachment by seeing the patient as a case to which he applies general rules and categories he has learned during training. The client, being personally involved, wants to judge and control what is happening, but does not share the practitioner's professional viewpoint. Therefore the means by which the solution is to be accomplished and the definition of the problem itself are sources of potential conflict. The professional deprecates the patient's judgement and believes that he defines the only truth. He is often unaware that his patient's opinion differs markedly from his own, as Hubert has suggested: "Just how little the scientific or medical explanations are accepted or even known about is obviously not comprehended by the people who know and try to communicate them" (18).

One important area where the gap in thinking is particularly wide is that of personality development (19). When I asked the women explicitly about this, it was clear that their ideas were ill-formed and vague. They simply did not think in these terms.

In sum, not only were the women unaware of the vast body of literature in this field, but their perspective was so very different from that of the academics and doctors that, in my view, it is unlikely that these research findings would have made much lasting impact even if they had been known to the women.

Spoiling.

Chapter Ten described how concerned the women were not to spoil their babies. They believed that spoilt babies grew into hateful, demanding

children and they thought that babies were spoilt as a result of being constantly picked up. They assumed that babies, even of a few weeks old, were capable of conscious actions and that they cried deliberately to receive attention.

The field of spoiling is an extremely contentious one. Some researchers agree with the women that young infants have a high hypothesis-testing ability; others feel that it is nonsense to suggest that babies are capable of such reasoning and planning. There is an urgent need for this question to be resolved. Until then, women like mine will continue to face the problem of how to deal with a crying baby and will tend to work on the assumption that picking him up will spoil him. This behaviour could be ultimately damaging to the child's personality. It is difficult to say until we have clearer evidence.

Solids.

Most mothers were also unsure about how and when to use solids, and they often came into conflict about this with the medical staff, particularly the Health Visitor. The argument against feeding solids to a very young baby is two-fold: first, the baby's digestive system is not equipped to cope with solid food at that age; and secondly, feeding babies solids tends to make them fat, which in turn makes them more likely to be over-weight as adults, with their increased risk of heart trouble. However, most of my women saw solids in a completely different light. To them, solids were the most effective way of stopping their babies from crying.

Most of them were aware that the Health Visitors generally disapproved of solids for young babies, but they seemed to have only a hazy idea of why this was so. This does not necessarily mean that the Health Visitors did not tell them; it may have been that the women were unable to listen. It would seem important to ensure that new mothers are told in detail of the effects solids can have upon a young baby. This is another area in

which further research into the effectiveness of different ways of presenting information to pregnant women would be very valuable. However, it is important to realize that one central reason why the women disregarded the Health Visitor's advice was because solids are an effective way of quietening babies, and therefore any attempt to persuade women to stop using solids would have to be accompanied by suggestions on alternative ways of pacifying babies. Furthermore, if the medical profession is convinced that it is desirable for women to adopt a more 'scientific' approach towards spoiling and solids, they need to find ways of communicating the relevant ideas to the mothers. This sort of information could probably best be given by a doctor in a session devoted solely to this after one of the hospital ante-natal Clinics. Alternatively, G.P.s could talk to a small group in their surgeries. The women I saw relied heavily upon the booklets they were given and therefore it would certainly be useful if these included a section on personality development, and in particular discussed this in the context of spoiling and the use of solids.

Communication between the Women and the Medical Staff.

Some medical staff were very good at explaining what they were doing to the women. However, as Chapter Four showed, others were not as forthcoming. Some volunteered some information, but not enough; others deterred their patients from asking questions by reacting abruptly to them, or failed to answer questions and explain why they were pursuing a certain course of action. Pat's inability first to find out why she was being induced earlier than normal, and secondly to discover what was wrong with her baby provides a vivid example of this lack of communication (20).

This reluctance of doctors to give information is not a new discovery. Caplan (21) saw this several years ago but he felt that obstetricians

could not be expected to recognize and discuss a patient's "emotional upsets" because "the professional persona of obstetricians does not include a professionalized means to maintain control over their own subjective reactions if they became sensitively aware of the emotional upheavals of their patients." Caplan argued that obstetricians had to maintain this stance in order to "focus their attention on maintaining the rapid flow of service" (22). His solution was to attach another worker to the team who could "deal with the crisis reactions of patients."

Another worker might be one answer, but surely obstetricians could be expected to realize that their patients need some straight-forward information and to give it when asked. Furthermore, the addition of another worker (which some British obstetric teams already have in the form of a social worker) presupposes that the doctors know how to use this person. In order to help doctors understand their patients' perspectives and make suitable and comprehensive referrals to this worker, their training should include a more systematic coverage of the behavioural sciences than it does at present.

Continuity of care (23) would also help. This might be difficult to achieve, but some consideration should be given to how the practical problems can be overcome. Under the present system at the hospital clinics the women were seen by whichever doctor was available.

Virtually all of them would have preferred to have seen the same doctor at each visit - this was one reason why most of them preferred attending their G.P.'s ante-natal clinic rather than the hospital's. They liked seeing the same doctor because they felt that once he had ceased to be a stranger, they were more able to discuss their medical condition with him and mention any small points that they would have found embarrassingly trivial to broach to a 'strange' doctor. It was precisely because

they felt that they knew their G.P. that they felt confident enough to question him. Thus continuity of care would have the advantages of relieving the women of nagging anxieties and perhaps of bringing issues to the attention of the medical staff which have greater significance than the patients realize. The women also felt that seeing the same doctor would ensure them a more personal service in that he would get to know them as well as their medical condition (24). The women seemed to be saying that they wanted to be treated as people rather than as stomachs.

Poor communication did not only exist between the doctors and the women; it also existed between the women and the ancillary medical staff. For example, some women tended to pay little attention to the Health Visitor over certain issues. This was partly because of the type of person she was and the way she presented herself. The women tended to prefer Health Visitors who were a little older than themselves (old enough to know better but not old enough to be old-fashioned) and who were married and had children themselves. They liked women who they saw as modern in outlook, efficient and knowledgeable, who spoke with authority but who only suggested rather than ordered. The popular Health Visitors were the ones who could sympathize and show that they understood the mother's predicament. If the Health Visitor did not present herself like this she was less likely to be listened to. Perhaps these mothers would have been more willing to listen if their Health Visitors had spoken more obviously from their own experience because this would have helped the women identify with them as mothers. It would also have been helpful if Health Visitors had made a point of letting mothers know that they are qualified nurses - many of my women did not realise this and therefore accorded more authority to the advice of the nurses in the hospital than they did to the Health Visitor. A Health Visitor who could present herself as being

slightly older, a mother herself and also a trained nurse would be listened to more attentively than many Health Visitors are at present.

Conclusion.

Two areas therefore emerge as vitally important for future work. We need research into how to present information to new mothers to help them cope with the anxieties that they experience, and we also need to think much more about how professional medical staff should present themselves to primiparae.

APPENDICES

APPENDIX I : THE HOSPITAL PROCEDURE

It was Edinburgh's policy that all women should have their first baby in hospital.

Expectant mothers were given a choice about their early ante-natal care. They could either attend their G.P. or the hospital where they hoped to have their child. If they chose the former, they would not necessarily be seen by their own G.P.; some practices had one doctor who ran their ante-natal clinics and so saw all the pregnant women in the practice. At this stage the appointments were every month.

Once they were thirty two weeks pregnant, however, all the women had to go to the hospital for their obstetric care. As their pregnancy progressed their appointments became increasingly frequent until in the last month they were attending weekly.

Around their third or fourth month all patients had to go to the hospital of their choice to book their bed for their delivery. This clinic was known as the Booking Clinic. Each hospital sent its patients a letter outlining what happened at the clinic. At the clinic they were examined internally, which helped the doctor work out the exact date of delivery. The opportunity was also taken of giving them a cancer smear test. There were also other routine examinations, such as blood -pressure tests and weight, and the women were usually given advice about their diet. Some hospitals used this clinic to invite the patients to attend the Relaxation Classes and Mothercraft Classes. At the end of the session, which usually lasted two or three hours, the women were told if there would be a vacancy for them. If not, they would have to approach another hospital.

The Classes were usually held by the hospital and run by one of the nursing staff. The Relaxation Classes taught the women how to relax and breathe during labour as a way of controlling the pain, whilst the

Mothercraft Classes gave them basic information about looking after themselves during pregnancy and how to care for their babies. There were usually four or five classes in each set and the women had some choice as to when they attended them.

APPENDIX II : THE RESPONDENTS' AGES, OCCUPATIONS AND HOUSING

<u>RESPONDENT</u>	<u>AGE</u>	<u>OCCUPATION</u>	<u>HOUSING*</u>
Agnes**	27	Shop Assistant	L.A.
Eric	29	Electrician	
Father		Bricklayer	
Mother		Cleaner	
Alison	22	Machinist	L.A.
Eddie	21	Railway Guard	
Father		Car-Park Attendant	
Mother		Hospital Domestic	
Anna	22	Engineering Tracer	L.A.
Paul	24	Laboratory Technician	
Father		Electrician	
Mother		Canteen Staff	
Brenda	17	Shop Assistant	P.R.
Steve	22	Panel Beater	
Father		Unknown (parents separated)	
Mother		Cashier	
Christine	21	Clerk/Bookkeeper	L.A.
Hamish	25	Foreman Labourer	
Father		Store Assistant	
Mother		Factory Worker	

<u>RESPONDENT</u>	<u>AGE</u>	<u>OCCUPATION</u>	<u>HOUSING*</u>
Elspeth	24	Secretary	O.O.
Douglas	23	Accountancy College Student	
Father		Salesman	
Mother		Telephonist	
Gina	22	Factory Worker	O.O.
Grant	21	Panel Beater	
Father		Fitter's Mate	
Mother		Housewife	
Helen	30	Clerk	P.R.
Bob	31	Scaffolder	
Father		Van Driver	
Mother		Home Help	
Jean	21	Shop Assistant	P.R.
Duncan	23	Bus Driver	
Father		Gardener	
Mother		Auxiliary Nurse	
Joan	21	Interior Display Designer	P.R.
Robert	21	Laboratory Photographer	
Father		Van Driver	
Mother		Deceased.	

<u>RESPONDENT</u> /	<u>AGE</u>	<u>OCCUPATION</u>	<u>HOUSING</u> *
Judith	26	Audiotypist	O.O
Alastair	27	Insurance Inspector	
Father		Foreman Labourer	
Mother		Housewife	
Julie	21	Nursery Nurse	A.Q.
Phil	23	Army Corporal	
Father		Research Design Development Engineer	
Mother		Cashier/Clerk	
Kathleen	19	Clerk	L.A.
Neil	21	Blacksmith Welder	
Father		Power Station Worker	
Mother		Shop Assistant	
Lynne	18	Microfilmer	P.R.
Rab	25	Glazier	
Father		Factory Worker	
Mother		Housewife	
Maggie	21	Clerk	L.A.
Jeff	22	Tiler	
Father		Photographer	
Mother		Shop Assistant	

<u>RESPONDENT</u>	<u>AGE</u>	<u>OCCUPATION</u>	<u>HOUSING*</u>
Moirra	27	Typist	L.A.
Angus	28	Electrician	
Father		Motor Mechanic	
Mother		Housewife	
Pamela	17	Apprentice Hairdresser	L.A.
Dylan	20	Electrician	
Father		Salesman	
Mother		Shop Assistant	
Pat	23	Shop Assistant	P.R.
John	25	Semi-Skilled Engineer	
Father		Labourer	
Mother		Factory Worker	
Ruth	30	Doctor's Receptionist	A.Q.
Bill	30	Army Private	
Father		Postman	
Mother		Housewife	
Sheila	22	Shop Assistant	L.A.
Mike	21	Electrician	
Father		Clerk	
Mother		Housewife	

<u>RESPONDENT</u> /	<u>AGE</u>	<u>OCCUPATION</u>	<u>HOUSING</u> *
Shirley**	27	Factory Worker	L.A.
Greg	28	Miner	
Father		Unknown	
Mother		"	
Sophie	25	Office Supervisor	O.O.
Charles	26	Work Study Engineer	
Father		Security Driver	
Mother		Landlady	
Sue	20	Factory Worker	L.A.
Gordon	20	Baker	
Father		Brewery Worker	
Mother		Cook	
Wendy	24	Reservations Assistant with Travel Agency	O.O.
Scott	24	Radio Operator (Merchant Ship)	
Father		Builder's Storeman	
Mother		Cook	

Notes : *Key - L.A. Local Authority O.O. Owner Occupier
P.R. Privately Rented A.Q. Army Married Quarters

**Multiparous

/ The parents are the respondent's parents.

APPENDIX III: THE QUESTIONNAIRES

The following questions formed the skeleton of the interviews.

First Interview: four to four and a half months pregnant.

1 I usually start by asking people how they came to realize that they were pregnant. How did you come to realize?

How did you feel on realizing?

Who did you tell first? How did they feel?

How did you feel when you told people?

2 When did you go to your G.P.?

What made you decide to go then?

Did you know your doctor well or not?

What happened when you saw him?

3 Have you decided where to have your baby?

Why did you chose that particular hospital? Have you much idea what it's like? Do you know much about the other hospitals? Has your husband/mother got any strong feelings about where the baby should be born?

How do you feel about going into hospital?

4 What was it like at the Booking Clinic?

Had you heard anything about the Booking Clinic before you went along?

How did you feel about your visit before you went/after you had been?

Did you talk to any of the other women there?

5 Where are you going for your ante-natal?

What made you decide to go there? What's it like?

6 Have you started getting your baby things together yet, or are you waiting a bit? (If waiting, why?)

What sort of things have you got already? Are friends and relatives helping out or not?

7 Is pregnancy like you thought it would be, or not?

Did you know much about pregnancy before you became pregnant?

Has your mother talked much about her pregnancies?

Have you thought much about the rest of the pregnancy?

Do you find yourself thinking much about the labour, or not?

Some people say that they don't like the thought of getting bigger, but other people say they want to show. How do you feel about that?

8 Do you find that people tell you what to do, or don't they bother?

9 Has anything been bothering you at all since you became pregnant?

10 I'd just like to ask you one or two factual questions now. Could you tell me what your husband's job is, please? And your's? What does your father do? Does your mother work?

Do you rent this house? (If so, is it privately rented or not?)

Do you mind telling me how old your husband is, and how old you are?

Second Interview: eight months pregnant.

1 How have you been keeping since I last saw you?

2 How are you getting on at the hospital?

(If embarrassed before) do you still feel embarrassed? (If so) why/why not?

Do you feel you can talk to the doctors or not?

3 Are you going along to any of the Classes? Why/why not?

What are they like?

Do you find them helpful?

4 Do you find yourself thinking about the baby at all?

Would you like a boy or a girl, or don't you mind? (If she has a preference) why do you think that?

What would your husband like? Why?

What sex do you think the baby is? What makes you think that?

Have you thought of any names yet, or not?

How do you feel about calling the baby after someone in the family?

How would you feel if they said you were going to have twins?

When you think about the baby inside you, do you think of it as a baby, or is it more just something that's there?

Do you think that all babies are the same, or not?

Do you think it takes a while to get to understand a baby - you know, to be able to know when it's crying because it wants feeding or when it wants attention? Or do you think you just know right away?

Do you think the baby will make much difference to you?

5 Can you imagine yourself as a Mum?

Are you looking forward to being a mother?

Is your husband looking forward to being a father?

6 How easy or difficult do you think things will be when you get home from hospital?

7 Have you decided yet how you're going to feed the baby? What made you decide to bottle feed/breast feed?

8 Do you think much about the birth now, or do you push it to the back of your mind?

Is your husband thinking of being there, or not?

9 Has being pregnant been like you thought it would be?

Do you still sometimes forget that you're pregnant or not? Some people say that it takes a while for it to sink in that you're pregnant. Did you find that or not?

10 Are you looking forward to getting your figure back?

Have people ever made jokes about the way you look, or not? Why do you think people do joke?

Have you ever found people staring at you in the street, or not?

11 Do you find that people tell you what you should and shouldn't do?

Third Interview: two months post-partum.

1 What was the birth like?

Did your husband stay with you or not? Did you find the Relaxation

Classes helpful or not? How did you feel on hearing it was a girl/boy?

What was your stay in hospital like? What were the nurses and doctors like?

2 Did the District Nurses call when you got home?

What were they like? Did you think their visits were helpful or not?

Did the Health Visitor call? What was she like? Did you think her visits were helpful or not?

3 What's it like, being a Mum?

Has it sunk in yet?

Do you think now that the Mothercraft Classes were helpful or not?

4 What was it like when you first got home from hospital?

Did the baby take a lot of getting used to? Did it fit into your routine, or did you fit into the baby's routine?

Do you think you can tell the difference between a sore cry and a lifted cry? How did you manage to tell the difference? How long did it take you before you could tell?

Now that you have a baby, do you think that all babies are the same or not?

Did you start to love your baby right away, or did it take some time before you loved him/her?

Do you think that babies have their own natures right from the start, or do you think that this develops?

5 Are you glad that you're bottle/breast feeding? Why?

6 Did you call the baby after anyone in the end? Did you give your baby a middle name?

7 How is your husband taking to being a father? Does he help much with the baby or not? Does he play with the baby or not?

8 Do you find that other people tend to give you lots of advice, or haven't they said much?

9 How has all this affected you?

10 Have you had your post-natal examination yet? (If so) what was it like? How did you feel?

Have you heard that saying, "When you're pregnant you leave your pride at the door and pick it up again on the way out." What do you think it means? When did you think you picked up your pride again?

11 Are you glad to have got your figure back, or aren't you bothered?/ are you dieting or exercising to get your figure back?

12 If you met some one today who was pregnant for the first time and she asked you for advice, what would you say to her?

FOOTNOTES

FOOTNOTES.

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8. There seem to be good arguments for early attendance. If induction or Caesarean section are considered, precise information on the duration of amenorrhoea ^{in relationship} to the size of the uterus is crucial - and this can only be known before the sixteenth week. Iron deficiency in early pregnancy may well also have some connection with low birth weight.
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- 10b. See Bewick, T., 1970 (footnote 14) where this is quoted (p.157). loc. See footnote 13 (p.14).
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15. Bibring, G., op. cit. And see Bibring, G., 1959, "Some Considerations of the Psychological Processes in Pregnancy," 14, 113-121.
16. Caplan, G., 1961, An Approach to Community Mental Health, Tavistock, London.
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CHAPTER TWO.

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2. For a description and evaluation of depth interviewing see Gorden, R.L.,1956, "Dimensions of the Depth Interview," Am. J. Soc., 62,150-64.
3. All the names are fictitious.
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5. This question is considered more fully later in the chapter. For a discussion of this see Hyman,H.H. et al.,1955, Interviewing in Social Research, Univ. of Chicago Press,Chicago.
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 15. See Chapter Four.
 16. Although the women saw me as a friend, I was aware that, in order to fulfil the role of researcher, I had to avoid becoming too intimate. See Gold, R.L., 1958, "Roles in Sociological Field Observation," Social Forces, 36, 217-223.
 17. Hargreaves, D.H., 1967, Social Relations in a Secondary School, Routledge and Kegan Paul, London.
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 20. Becker, ibid, describes the advantages of this type of approach much more fully.

21. Easthope, G., 1974, A History of Social Research Methods, Longman, London, chapter 7.
22. See Whyte, W., 1943, Street Corner Society, Univ. of Chicago Press, Chicago and London. Whyte found, "As I sat and listened, I learned the answers to questions that I would not even have had the sense to ask if I had been getting my information solely on an interviewing basis." (p.303)
23. Bott, E., op.cit., p.49: "It is doubtful if anthropological methods could be used in studying urban neighbourhoods without serious modification of the basic approach, because most urban neighbourhoods are not organized groups."
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CHAPTER THREE.

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2. For example, see Cartwright, A., 1964, Human Relations and Hospital Care, Routledge and Kegan Paul, London, and Freidson, E., 1961, Patients' Views of Medical Practice, Russell Sage Foundation, New York, especially p.210-211. Freidson argued that the higher classes are more able to question doctors, whereas the lower classes are more passive and less critical about their medical care. The upper middle class patient sees himself as his doctor's equal and is more detached and informed in his relationship to his doctor than is his lower class counterpart.

3. Goldthorpe, J.H. and Hope, K., 1974, The Social Grading of Occupations: A New Approach and Scale, Clarendon Press, Oxford, especially p.3-21.

4. Classification of Occupations, 1970, H.M.S.O., p.x.

5. Groups 1-4 are: employers and managers in central and local government, industry, commerce, etc. in large (1) and small (2) establishments; and professional workers, self-employed (3), and employees (4).

CHAPTER FOUR.

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2. van Gennep, A., 1909/1960, The Rites of Passage, Routledge and Kegan Paul, London.

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8. Silver, G., 1963, Family Medical Care, Harvard Univ. Press, Cambridge, Mass., especially p.169-72.

9. Goffman, E., 1958, Presentation of Self in Everyday Life, Univ. of Edinburgh Social Science Research Centre, Monograph No. 2, especially p.160-161. Goffman writes that in the absence of "full information," "the individual tends to employ substitutes - cues, tests, hints, expressive gestures, status symbols, etc. as predictive devices. In short, since the reality that the individual is concerned with is unperceivable at the moment, appearances must be relied upon in its stead. And, paradoxically, the more

the individual is concerned with the reality that is not available to perception, the more must he concentrate his attention on appearances."

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11. Berger, P.L., and Luckmann, T., 1966, The Social Construction of Reality, Penguin, London.

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13. Newson, J. and Newson, E., 1972, Patterns of Infant Care, Penguin, London, p. 21.

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15. One interesting ramification of this was the embarrassment one or two women obviously felt when they realized that they had described their experiences to me, a mere 'novice,' in such detail. They overcame it by splitting me off from the general run of 'novices' and reminding themselves that they "had to tell" me.

16. Banton, M., 1965, Roles, Tavistock Publications, London, p.101.

17. See Chapter Eight.

18. See Chapter Six.

19. In order to try and ensure that the baby would be "alright" the women often resorted to superstitious behaviour almost in an attempt not to 'tempt fate.' For example, Elspeth bought a chest specially for her baby clothes, but then refused to put any in it until she had persuaded her husband to fill a drawer with his things first. Similarly, several women delayed buying their pram until the baby was born.

20. See Chapter Ten.

21. See Chapter Seven.

22. Forbes, T.R., 1966, The Midwife and the Witch, Yale Univ., New Haven.

23. See Chapter Five.

24. Gross E. and Stone,G.P., 1964, "Embarrassment and the Analysis of Role Requirements," Am. J. Soc., 70, 1-15, especially p.6-7.
25. Ivan Illich decribed how the modern attitude toward pain is to try at all costs to get rid of it in the Encyclopedia Britannica Lecture at Edinburgh University on 26.4.74. He argued that the medical civilization has eliminated the need to come to terms with pain,with what he sees as the lamentable result that people today cannot give either meaning or dignity to it. Therefore they try to avoid it.
26. Klein,H.R., Potter,H.W. and Dyk,R.B., op.cit. See p.41: they suggest that in addition to the practical aspects involved in a fear of delivering a baby outside hospital (e.g. lack of sterile conditions,etc.), because the women picture themselves as being left alone,a fear of being deserted or rejected is often also implied.
27. All the hospital names are fictitious.
28. Richards,I.D.G., Donald,E.M., and Hamilton,F.M.W., 1970, "Use of Maternity Care in Glasgow," in McLachlan,G. and Shegog,R., In the Beginning, Oxford Univ. Press. They claim that the G.P. was a key figure in selecting the place of confinement and that a high proportion of women accepted his decision,but my data does not suggest that the G.P. played such a major role as far as my women were concerned.
29. Lynne's dizzy spells were really more than "turns"; they involved her in losing consciousness for an appreciable length of time. They could have been dangerous if only in so far as they could have occurred when she was crossing the road in front of a vehicle. The "You and Your Baby" hospital booklet says," Faintness and Dizziness: These are extremely common symptoms in early pregnancy,and are probably due to increased blood flow to the pelvic organs,so that,for very brief moments,the blood supply to the brain is insufficient for its needs. This is especially likely to occur on getting up from a chair or out of bed. There is no

harm in this kind of faintness and it can usually be prevented by moving rather slowly from lying or sitting to a standing position."

30. "Show" : when the mucous plug comes away it leaves a stain on the panties. "Breaking of the waters" : the release of the amniotic fluid from the womb once the early contractions have ruptured the membrane.

31. Holt,E.M., 1971, "Induction of Labour," Midwife and Health Visitor, 7, 262-4 describes what happens during induction.

32. Gillie,O. and Gillie L., 13.10.74., "The Childbirth Revolution," The Sunday Times Weekly Review, and McHardy,A., 23.1.75., "Medical Division on Induced Birth," The Guardian.

33. "Obstetrics: Inducing Labour," The Times,16.12.74, and Jordan,P., 9.12.74., "Birth by Rota Induces Bitterness," The Guardian.

34. Illich,op.cit. Illich described one of the characteristics of medical nemesis as an addiction to doctors and drugs,which encourages people to stop dealing with their medical problems in their own way.

35. Reminiscent of the "echoing walls of civility" of the Indians of Chandrapore - well mannered and charming but utterly frustrating and seemingly impossible to penetrate. Forster,E.M., 1924/1969, A Passage to India, Penguin,London,p.43.

36. Roth,J.,1963,"Information and Control in Tuberculosis Hospitals," in Freidson,E., The Hospital in Modern Society, Free Press of Glencoe,New York.

37. Richardson,A.S. and Cuttmacher,A.F., 1967, Childbearing - its Social and Psychological Aspects, Williams and Wilkins,U.S.A.

38. Glaser,B.G. and Strauss,A.L., 1966, Awareness of Dying, Weidenfeld and Nicolson,London,p.53-5.

39. Caplan,G., 1964, Principles of Preventive Psychiatry, Tavistock Pubs., London, p.71-2; and Caplan,G., 1956, Mental Health Aspects of Social Work in Public Health, Univ. of California Press, based on the proceedings

of an institute given by the School of Social Welfare, Univ. of California, p.70.

40. Bibring, G., 1959, "Some Considerations of the Psychological Processes in Pregnancy," Psychoan. Stud. Child, 14, 113-121, especially p.117-8.

41. Caplan, G., 1961, An Approach to Community Mental Health, Tavistock Publications, London.

CHAPTER FIVE.

1. Sherif, M., 1968, "Self Concept," The International Encyclopedia of the Social Sciences, 14, MacMillan Comp. and the Free Press, 150-9.

2. McKinlay, J.B., 1972, "The Sick Role - Illness and Pregnancy," Social Science and Medicine, 6, 561-572.

3. Burr, W., 1972, "Role Transitions: A Reformation of Theory," J. of Marriage and the Fam., 34, 407-416.

4. Banton, M., 1965, Roles, Tavistock Publications, London, p.94.

5. For a description of this custom, see Thomas, K., 1971, Religion and the Decline of Magic, Wiedenfield and Nicolson, London, p.59ff.

6. Goffman, E., 1973, Stigma, Pelican, London, p.95.

7. Banton, M., op.cit. p.112.

8. See, for example, Glaser, B.G. and Strauss, A.L., 1965, "Temporal Aspects of Dying as a Non-scheduled Status Passage," Am. J. Soc., 71, 48-59.

9. Goffman, E., op.cit. p.57.

10. Jacoby, A., 1969, "Transition to Parenthood: A Reassessment," J. of Marriage and the Family, 31, 720-27.

11. Newson, J. and Newson, E., 1963, Patterns of Infant Care, Pelican, London.

12. Berger, P., 1969, Invitation to Sociology, Penguin, London, p.121.

13. Coser, R., 1966, "Role Distance, Sociological Ambivalence and Transitional Status," Am. J. Soc., 72, 173-87.

14. It might be helpful to see this in the context of "taking the role of

- the other" - see for example, Mead, G., 1934, Mind, Self and Society, Univ. of Chicago Press, Chicago, 152-64; and Shibutani, T., 1955, "Reference Groups as Perspectives," American Journal of Sociology, 60, 562-69.
15. Goffman, E., op.cit. p.49.
 16. Newson, J. and Newson, E., op.cit. p.19.
 17. Berger, P., op.cit. p.117.
 18. Goffman, E., 1953, Presentation of Self in Everyday Life, Univ. of Edinburgh Social Science Research Centre, Monograph No. 2.
 19. Polhemus, T., 1975, "Social Bodies," in Benthall, J. and Polhemus, T., The Body as a Medium of Expression, Allan Lane, London, 13-35.
 20. Simone de Beauvoir has taken this a step further. She has argued that when "confronting man, woman is always play-acting; she lies when she ... presents to him an imaginary personage through mimicry, costumery, studied phrases... With other women, a woman is behind the scenes, she is polishing her equipment but not in battle, she is getting her costume together, preparing her make-up, laying out her tactics." de Beauvoir, S., 1953, The Second Sex, (translated by Parshley, H.M.) Knopf, New York.
 21. Bennett, A., 1908/1963, The Old Wives' Tale, Everyman's Library, London, p.313.
 22. My underlinings.
 23. Banks, L.R., 1960, The L-Shaped Room, Penguin, London, p.220.
 24. McKinlay, J.B., 1970, Some Aspects of Lower Working Class Utilization Behaviour, unpublished Ph.D. thesis, Aberdeen University, Aberdeen.
 25. I think McKinlay missed the fact that women (especially "lower working class women") are embarrassed during their ante-natal care, and I think he missed it because of his interviewing schedule. As Chapter Seven of my thesis shows, the women were most embarrassed during their visit to the Booking Clinic. McKinlay's first interview was timed to take place two weeks after the women's first ante-natal visit - which would probably occur before they had been to the Booking Clinic. And moreover, his first

- interview concentrated on superficial data (e.g. length of time lived in the area); it was not until the second interview at 34-36 weeks that he began to ask about attitudes. By that time the embarrassing memory of the Booking Clinic would doubtless have been mellowed by subsequent ante-natal care and overshadowed by the prospect of the birth.
26. See Ford,C. and Beach,F., 1951, Patterns of Sexual Behaviour, Ace Books, New York. They describe how different societies have different beliefs as to what constitutes a beautiful body.
27. See "From Here to Maternity," The Guardian, 24.4.73. Two models and a boutique assistant discussed the clothes they wore during their first pregnancy: "Nothing would induce them to set foot inside a maternity shop proper; they were all determined to make their own clothes from patterns or buy them from non-maternity rails."
28. For further discussion of Ruth's position, see Chapters Six and Eleven.
29. Swift, J., 1726/1967, Gulliver's Travels, Penguin, London.
30. For a more detailed discussion of body image see Chapter Six.
31. Sherif, M., op.cit. p.153.
32. Jessner, L., Weigert, E. and Foy, J.L., 1970, "The Development of Parental Attitudes during Pregnancy," in Anthony, J. and Benedek, T., Parenthood, Little Brown and Comp., Boston. See p.219: Judith's feelings were strikingly similar to those of Mrs. O: "Mrs.O. was plagued by a dream. She was in an auditorium and a girl in a sexy black dress was there too. Mrs. O's husband got up to sit with the girl. The dream reminded Mrs.O. that she was self-conscious about her figure and afraid of losing what had been most precious in her life - to be a woman and in love."
33. Goffman, E., Stigma, op.cit. p.66.
34. Ibid.
35. Banton, M., op.cit. p.72.
36. It is interesting to compare this with Ford, C., and Beach, F., op.cit.

who, in their description of the mores governing menstruating women, state that even the lenient primitive societies insist that such women discontinue dancing.

37. Hamilton, E., 1954, Emotional Aspects of Pregnancy, unpublished doctoral dissertation, Columbia Univ. She noted that some male strangers tended to be overly flirtatious with pregnant women (see p. 162).

38. Goffman, E., "Presentation of Self in Everyday Life," op.cit., p.37ff.

39. For example, Deutsch, H., 1947, The Psychology of Women, Research Books, Ltd., London; and van Gennep, 1909/1960, The Rites of Passage, Routledge and Kegan Paul, London.

40. See MacRae, D., 1975, "The Body and Social Metaphor," in Benthall, J., and Pohlhemus, T., op.cit., 59-73.

CHAPTER SIX.

1. Fisher, S., 1968, "Body Image," The International Encyclopedia of the Social Sciences, 2, MacMillan Company and the Free Press, 113-16.

2. Caplan, G., 1964, Principles of Preventive Psychiatry, Tavistock Publications, London, p.69.

3. Bloss, J.R., 1950, "Causes of Fear among Obstetric Patients," Journal of American Medical Association, 144, 1358-61.

4. Loesch, J.G. and Greenberg, N.H., 1962, "Some Specific Areas of Conflict Observed during Pregnancy: A Comparative Study of Married and Unmarried Women," American Journal of Orthopsychiatry, 32, 624-34.

5. Deutsch, H., 1947, The Psychology of Women, Pt.II, Research Books, Ltd., London.

6. Pohlhemus, T., 1975, "Social Bodies," in Benthall, J. and Pohlhemus, T., The Body as a Medium of Expression, Allen Lane, London, 13-35.

7. Compare with Pharoah, N., 1968, "Escape into Pregnancy," New Society,

12. 399-402. Pharoah found that some girls feigned pregnancy for the social rewards it offers (namely sympathy and escape from responsibility.)
8. Goffman,E., 1973, Stigma, Pelican, London, p.61.
9. Sherif.M., 1968, "Self Concept," The International Encyclopedia of the Social Sciences, 14, MacMillan and Company, and the Free Press, p.157.
10. Boston,R., 1974, An Anatomy of Laughter, Collins, London.
11. Freud,S., 1905, Jokes and their Relation to the Unconscious, Routledge and Kegan Paul, London.
12. Goffman,E., 1956, "Embarrassment and Social Organization," Am. J. Soc. 62, 264-71.
13. Goffman,E., Stigma, op.cit. p.33.
14. Ibid, p.18.
15. Berger,P.,and Kellner,H., 1964, "Marriage and the Construction of Reality," Diogenes, 46, 1-24.
16. Berger,P., 1963, Invitation to Sociology, Pelican,London, p.119.
17. Berger,P. and Kellner,H. op.cit. p.5. They quote Schutz as arguing that the bestowing force of social relationships depends on the degree of their nearness, that is, on the degree to which social relationships occur in the face-to-face situation and to which they are credited with primary significance by the individual. Thus Sophie's male colleagues were particularly well-placed to reinforce her sexual identity. (Schutz, A., ¹⁹⁶⁰ Der Sinnhafte Aufbau der Sozialen Welt, Vienna, Springer, 131-95.)
18. Berger,P., op.cit. p.119.
19. McHugh, P., 1968, Defining the Situation, Bobbs Merrill, New York.
20. See Goffman,E., Stigma, op.cit. p.24, for a brief discussion of the relationship between inferiority, insecurity and anxiety.
21. There is probably a link here with sexual activity. See Jessner, L. Weigert, E., and Foy, J.L., 1970, "The Development of Parental Attitudes during Pregnancy," in Anthony, E.J., and Benedek, T., Parenthood, Little

Brown and Company, Boston, p.219. They reported that during pregnancy sex loses much of its spontaneous pleasure - respondents complained of losing capacity and enthusiasm, and, despite doctors advising them to the contrary, many believed it could harm the baby: "childhood concepts of sex as sinful or impure, irreconcilable with the idea of a mother, would not let them accept the medical dictum with ease."

22. Dennis, N., Henriques, F. and Slaughter, C., 1956, Coal is Our Life, Tavistock Publications, London.

23. Gorer, G., 1971, Sex and Marriage in England Today, Nelson, London, see Chapter Five.

24. Bloss, J.R., op.cit.

25. Berger, P. and Kellner, H., op.cit. p.22.

26. Breen, D., 1975, The Birth of a First Child, Tavistock Publications, London.

27. Goffman, E., 1970, Strategic Interaction, Blackwell, Oxford, especially p.12-3.

28. Goffman, E., 1969, Encounters, Allen Lane, London, p.95.

29. Coser, R.L., 1966, "Role Distance, Sociological Ambivalence, and Transitional Status Systems," Am. J. Soc., 72, 173-87.

30. Goffman, E., Strategic Interaction, op.cit.

31. Goffman, E., 1958, Presentation of Self in Everyday Life, Univ. of Edinburgh Social Science Research Centre, Monograph No. 2, chapter 3.

32. Goffman, E., Strategic Interaction, op.cit.

33. Goffman, E., Presentation of Self in Everyday Life, op.cit. p.70.

34. Ibid, p.67: "It may also be noted that while decorous behaviour may take the form of showing respect for the region and setting one finds oneself in, this show of respect may, of course, be motivated by a desire to impress the audience favourably."

35. Goffman, E., Stigma, op.cit. p.17.

36. Ibid, p.29, 91.
37. Pohlemus,T., 1973, "Fashion,Anti-fashion and the Body Image," New Society,26, 73-6.
38. Pohlemus,T., 19.3.74., "Tasty or Tarty?" The Guardian.
39. Tweedie,J., 3.2.75., "Wild Oats,Cold Porridge," The Guardian.
40. Stott,M., 29.5.75., "Mirror,Mirror," The Guardian.
41. Rainwater,L., Coleman,R.P. and Handel,G., 1968, "The Inner Life and Outer World of the Workingman's Wife," in Sussman,M., Sourcebook of Marriage and the Family, Houghton Mifflin,Comp., Boston, especially p.187-8.

CHAPTER SEVEN.

1. Argyle,M., 1972, The Psychology of Interpersonal Behaviour, Penguin, London, p.166.
2. Goffman,E., 1955, "On Face-Work," Psychiatry, 18, 213-231; and Goffman,E., 1956, "Embarrassment and Social Organization," Am. J. Soc., 62, 264-71.
3. Gross,E., and Stone,G.P., 1964, "Embarrassment and the Analysis of Role Requirements," Am. J. Soc., 70, 1-15.
4. Goffman,E., "Embarrassment and Social Organization," op.cit., p.265.
5. Gross,E. and Stone,G.P., op.cit.,
6. Ibid, p.9.
7. Ibid, p.15. 7b. Therefore women who attended the Family Planning Clinic were less likely to be embarrassed at the Booking Clinic - although some still felt embarrassed if this was their first examination by a male doctor.
8. Thompson,L.J., 1942, "Attitudes of Primiparae in a Prenatal Clinic," Mental Hygiene, 26, 243-56.
9. Klein,H., Potter,H. and Dyk,R., 1950, Anxiety in Pregnancy and Child-Birth, Paul Hoeber,New York, p.69.
10. Emerson,J., 1970, "Behaviour in Private Places," in Dretzel,H., (ed.) Recent Sociology, No. 2, MacMillan,New York, 73-96.
11. The data also tentatively suggests that the lower the class,the more

embarrassed the woman was likely to be. This, of course, fits in with literature on class and sexuality, e.g. Rainwater, L., 1960, And the Poor Get Children, Quadrangle Books, Chicago.

12. See Kinsey, A. et al., 1948, Sexual Behaviour in the Human Male, W.B. Saunders and Company, Philadelphia and London, p.365-7. They showed that the lower classes in the U.S.A. considered nudity to be "obscene" : "It is obscene in the presence of strangers, and it is even obscene in the presence of one's spouse."

13. Goffman, E., "On Face-Work," op.cit. p.215.

14. For a brief discussion of the intimate relationship with embarrassment that the medical profession enjoys, see Ricks, C., 1974, Keats and Embarrassment, Clarendon Press, Oxford, p.26-7. And for a consideration of interns' affective involvement with patients see Daniels, M., 1960/1, "Affect and Control in the Medical Intern," Am. J. Soc., 66, 259-67.

15. Goffman, E., "Embarrassment and Social Organization," op.cit. p.268.

16. Deutsche, H., 1947, The Psychology of Women, Vol.II, Research Books, Ltd., London, p.136.

17. Darwin, C., 1872, The Expression of the Emotions in Man and Animals, p.326-7, quoted in Ricks, C., op.cit.

18. Goffman, E., "Embarrassment and Social Organization," op.cit., p.270-1.

19. MacCurdy, J., 1930, "The Biological Significance of Blushing and Shame," British Journal of Psychiatry, 21, 174-32. See especially p.181. He points out that a private as well as public taboo is laid on sex, and that this alone would tend to make sex the most important cause of embarrassment in our civilization.

20. Weinberg, M., 1968, "Sexual Modesty, Social Meanings and the Nudist Camp," in Truzzi, M., (ed.) Sociology and Everyday Life, Prentice Hall Inc., Englewood Cliffs, New Jersey, 212-220.

21. Emerson, J., op.cit., especially p.87-8.
22. Ricks, C., op.cit. p.88; and Goffman, E., "Embarrassment and Social Organization, op.cit., p.269.
23. Weinberg, M., op.cit., p.213; and Goffman, E., 1956, "The Nature of Deference and Demeanour," American Anthropologist, 63, p.492.
24. Emerson, J., op.cit., p.83.
25. Goffman, E., "On Face-Work," op.cit., p.214.
26. My underlinings.
27. Richman, J., Bedford, J., and Goldthorp, W., 21.11.74., "The Gynaecologist: Friend or Foe?" New Society, 474-6.
28. Emerson, J., op.cit. p.82.
29. Ricks, C., op.cit., p.84-6. See Keats' vicarious lack of embarrassment in the presence of Jane Cox's self-possession and freedom from embarrassment.
30. Perhaps the doctors' joking manner also allowed the women to "take the line that they are good sports, able to relax from their ordinary standards of pride and honour" - see Goffman, E., "On Face-Work," op.cit. , p.218. Banter is also " a way of saying that what occurs now is not serious or real.... It is natural to find embarrassment and joking together, for both help in denying the same reality." See Goffman, E., "Embarrassment and Social Organization," op.cit., p.271.
31. Gillie, O., 23.10.73., "How You Can Look After Your Body," The Sunday Times.
32. Women are encouraged to see doctors as potential "heart-throbs" by the media (see such programmes as "Dr. Kildare," "Emergency Ward 10," and, more recently, "General Hospital.") See the Sunday People, 17.11.74.: "Millions of housewives have discovered a new recipe for romance. For them, every Thursday and Friday at two p.m. love in the afternoon has

become more than an idle dream. Because that's when they tune in to the twice a week serial, "General Hospital".... that's when the happy housewife can enjoy looking at the five regular dishy doctors." And John Illman in The Sunday Times recently mentioned "a strange 'pen-friend' service (which) has developed out of the strong association between romance and the doctors' surgery." The Medical Defence Union "provides amorous patients who write letters to their doctors with an emotional outlet whilst protecting doctors from the threat of allegations about illicit relationships with patients."

33. Klein, H., Potter, H and Dyk, R., op.cit. They quote Kroger and Freed, 1943, American Journal of Obstetrics and Gynaecology, 46.

34. Gross, E. and Stone, G.P., op.cit., p.14.

35. Ford, C.S., 1945, A Comparative Study of Human Reproduction, Yale University Publications in Anthropology, No. 32, Yale University Press, New Haven.

36. Hubert, J., 1974, "Social Factors in Pregnancy and Childbirth," in Richards, M.P.M., (ed.) The Integration of a Child into a Social World, Cambridge University Press, Cambridge, 37-51, especially p.45. She also noted that some of her sample found the birth embarrassing.

37. Goffman, E., 1958, Presentation of Self in Everyday Life, University of Edinburgh Social Science Research Centre, Monograph No. 2, p.34ff.

38. See Burchell, C.R., 1964, "Predelivery Removal of Pubic Hair," Obstetrics and Gynaecology, 24, 272-3. He argued that shaving is unnecessary.

39. Hamilton, E., 1954, Emotional Aspects of Pregnancy, unpublished doctoral dissertation, Columbia University, p.246-7.

40. Goffman, E., Presentation of Self in Everyday Life, op.cit., p.33-4.

41. Deutsche, H., op.cit., p.219.

42. Gross, E. and Stone, G.P., op.cit. p.8.

43. See Ricks' discussion of indignation driving out embarrassment
-op.cit. p.3.

44. See Storr, A., 31.3.74., "The Conscious Self," The Sunday Times; and
also Goffman, E., "On Face-Work," discusses face-work's protective orientation towards saving the other's face (op.cit.).

45. Gross, E. and Stone, G.P., op.cit. p.2.

46. Sattler, J., 1965, "A Theoretical, Developmental and Clinical Investigation of Embarrassment," Genetic Psychology Monographs, 71, p.22.

47. See Emerson, J., op.cit., for a discussion of indicators that the scene is enacted under medical auspices - e.g. medical space, medical uniforms and exclusion of lay persons. The props and the setting emphasize the medical definition of the situation. See especially p.80-1.

48. See Rainwater, L., op.cit.; he found that the lower class women were much more indifferent to or repelled by sexual relations than upper class women.

49. She said, "I think of it more as just something that's there... I think, well, you don't really know what it LOOKS like... You wonder what it WILL look like, so you never really think of it AS a baby. Because you don't know what it looks like, or anything!"

50. My underlinings.

51. Goffman, E., "Embarrassment and Social Organization," op.cit., p.270-1.

52. Goffman, E., "On Face-Work," op.cit., p.214.

CHAPTER EIGHT.

1. see Illich, I., 1974, "Medical Nemesis: The Destructive Force of Professional Health Care," Social Policy, 5, 3-9, for a discussion of the unbearable and unmanageable aspect of pain in modern society.

2. Mead, M and Newton, N., 1967, "Cultural Patterning of Perinatal

Behaviour," in Richardson,A.S. and Guttmacher,A.F.,Childbearing - It's Social and Psychological Aspects, Williams and Wilkins,U.S.A.,142-244.

This discussion draws in part on their work.

3. Levin,S., 1960, "Obstetrics in the Bible," Journal of Obstetrics and Gynaecology of the British Empire, 67, 490-7.

4. Kitzinger,S., 1973, Giving Birth, Sphere, London, provides a contrast here. Her women do not emphasize their pain and suffering.

5. Lyman,S.M. and Scott,M.B., 1968, "Coolness in Everyday Life," in Truzzi,M., (ed.),Sociology and Everyday Life, Prentice Hall,Inc., Englewood Cliffs,New Jersey, 92-101.

6. Goffman,E., 1955, "On Face-Work," Psychiatry, 18, 213-231.

7. Hubert,J., 1974, "Social Factors in Pregnancy and Childbirth," in Richards,M.P.M.(ed.) The Integration of a Child into a Social World, Cambridge University Press, Cambridge. Hubert found that, "Some would have liked to have known more about it,a few were scared at the idea of pain,but the general assumption seemed to be that it would all be quite straightforward." Here my women differed considerably from Hubert's - perhaps as a result of their slightly higher class and possible greater sophistication.

8. Breen,D.,1975, The Birth of a First Child, Tavistock Publications, London. See especially p.168: her respondents who had strong anaesthetics said that it took them a very long time to regard their babies as really theirs because they had not had the feeling of having given birth to them. Breen remarked that this had been one of the arguments in the literature in favour of natural childbirth and active participation from women.

9. Gross,E. and Stone,G.P., 1964, "Embarrassment and the Analysis of Role Requirements," Am. J. Soc., 70, p.15.

10. Ford,C.S., 1945, A Comparative Study of Human Reproduction, Yale Univ.

- Publications in Anthropology, No. 32, Yale University Press, New Haven.
11. Thomas, K., 1971, Religion and the Decline of Magic, Weidenfeld and Nicolson, London; and Forbes, T.R., 1966, The Midwife and the Witch, Yale University, New Haven.
 12. After the ancient system of classification - see Forbes, T.R., ibid.
 13. Brand, J., 1913, Brand's Observations on Popular Antiquities, Chatto and Windus, London, p. 331.
 14. See Forbes, T.R., op.cit. chapter 6; and Buhler, C.F., 1964, "Prayers and Charms in Certain Middle English Scrolls," Speculum, 39, 270-8. Word charms remained popular until the nineteenth century.
 15. Bibring, G., 1959, "Some Considerations of the Psychological Processes in Pregnancy," Psychoanalytic Study of the Child, 14, 113-121.
 16. My underlinings of the "islands."
 17. Gross, E. and Stone, G.P., op.cit.: "Since embarrassing situations are inevitable in social life, persons must be schooled to maintain poise when poise is threatened." The Relaxation Classes helped perform this schooling.
 18. See Chapters Six and Eleven for a fuller description of this type of woman.
 19. Caplan, G., 1964, Principles of Preventive Psychiatry, Tavistock Publications, London. See particularly p. 70, where he stresses the importance of routine preparation of patients because it gives them time to work through some of their feelings and achieve anticipatory mastery which makes events easier to bear.
 20. My underlinings pick out the salient coping mechanisms.
 21. See the preceding section.
 22. Newton, N., 1963, "Emotions of Pregnancy," Clinical Obstetrics and Gynaecology, 6, 639-68, especially p. 660-2.

23. Chertok, L. et al., 1962, "Elements psychologiques du pronostic de l'accouchement," Proceedings of the First International Congress of Psychosomatic Medicine and Childbirth, Ganthier-Villass, Paris, (quoted in Newton, ibid.)
24. For a medical assessment of induction see Holt, E.M., 1971, "Induction of Labour," Midwife and Health Visitor, 7, 262-4.
25. Fortes, M., 1962, "Ritual and Office in Tribal Society," in Gluckman, M., (ed.) Essays on the Ritual of Social Relations, Manchester University Press, Manchester, 53-88.
26. See also Newson, J. and Newson, E., 1972, Patterns of Infant Care, Penguin, London, especially p.20: "prestige of the initiated is maintained by ordeal of pain and suffering."

CHAPTER NINE.

1. See Berger, P. and Kellner, H., 1964, "Marriage and the Construction of Reality," Diogenes, 46, 1-23. This process is similar to Berger and Kellner's "talking through" in marriage when "the objectifications ongoingly performed and internalized by the marriage partners become ever more massively real, as they are confirmed and reconfirmed in the marital conversation."
2. See Parsons, T. (ed.), 1964, Weber: The Theory of Social and Economic Organization, Free Press, London, p.16. In his introduction, Parsons begins to define a rational act by saying that an act is rational in so far as
(a) it is orientated to a clearly formulated, unambiguous goal, or to a set of values which are clearly formulated and logically consistent,
(b) the means chosen are, according to the best available knowledge, adapted to the realization of the goal.
3. This could have important consequences, as I suggest in my conclusion

to Chapter Eleven when I refer to Ounsted's work on battered babies.

4. Aries,P., 1962,Centuries of Childhood, Johnathan Cape, London.

5. Rossi,A., 1968, "Naming Children in Middle Class Families", in Sussman,M., Sourcebook in Marriage and the Family, Houghton Mifflin Comp., Boston, 159-72

6. Klein,H.R., Potter,H.W. and Dyk,R.,1950, Anxiety in Pregnancy and Childbirth, Paul B. Hoeber, New York, p.30-1.

7. Forbes,T.R., 1966, The Midwife and the Witch, Yale University, New Haven, Chapter 4.

8. Newson,J. and Newson,E., 1972, Patterns of Infant Care, Penguin, London.

9. Ibid. See p.184: "the infant's behaviour,in the first few months,is frequently evaluated in moral terms." It is interesting to speculate how far this is a hang-over from earlier (e.g. Calvinistic) ideas that children were "imps of darkness". For example,see Helfer,R. and Kempe, C.H.,1968, The Battered Child, University of Chicago Press,Chicago.

10. This area is a contentious one. For example,Leach,P.,1973, Babyhood, Penguin,London,feels that to suggest that babies are capable of such conscious actions is a "risky way of looking at the problem. It suggests that the infant is capable of a kind of reasoning and planning which will be impossible for him for months to come." However,I am grateful to Dr. M. Anderson for drawing my attention to some ongoing work in the Psychology Department at Edinburgh University under Dr. I.,Trevarthen, which suggests that babies do,in fact,possess quite a high hypothesis testing ability.

11. See the next Chapter for a further discussion of this premise.

12. Contrast with primitive societies who generally give the baby the breast whenever it cries and who have a lot of physical contact with the baby - for example, see Leach, P., op.cit., p.73-9.

CHAPTER TEN.

1. Berger, P. and Luckmann, T., 1966, The Social Construction of Reality, Penguin, London.

2. See Chapter Nine.

3. Rossi, A., 1968, "Transition to Parenthood," Journal of Marriage and the Family, 30, 26-39.

4. The problem of babysitters led to a further problem: in order to be what Anna called "a proper person" (i.e. 'normal'), most of the women were keen to enjoy a social life. However, this goal was complicated by the problem of working out who was to be trusted as a reliable babysitter.

5. Sunley, R., 1955, "Early Nineteenth Century American Literature on Child-rearing," in Mead, M. and Wolfenstein, M. (ed.), Childhood in Contemporary Cultures, University of Chicago Press, Chicago, 150-67.

6. This prefigures people's behaviour today in giving their babies paracetamol and gripe water, both of which are drugs.

7. See, for example, Bid, E.E., ¹⁹⁷⁰ "Follow-up Study of Physical Growth of Children who had Excessive Weight Gain in their first Six Months of Life," British Medical Journal, 2, 74-6; Shukla, A., Forsyth, H.A., Anderson, C.M., and Marwah, S.M., 1972, "Infantile Overnutrition in the First Year of Life: A Field Study in Worcestershire," British Medical Journal, 4, 507-515; Oates, R.K., 1973, "Infant-feeding Practices," British Medical Journal, 2, 762-64; Fields, L., 8.2.76., "Fat Living for Baby," Observer.

8. Rose, A., 1962, Human Behaviour and Social Processes, Routledge and Kegan Paul, London. See the Preface.

9. Rationality was defined in the last chapter, where its significance for

the way a mother coped with her baby was first mentioned.

10. "Girnie": a Scottish term for some one who moans and cries.

11. Benedek,T., 1970, "The Family as a Psychologic Field," in Anthony,E. J. and Benedek,T., (ed.) Parenthood, Little,Brown and Co., Boston, 109-36.

12. Helen's explanation that Clare was spoilt could have interesting repercussions. Her conclusion that Clare was "niggley" might lead to her labelling her child as bad-tempered as she grew older, and treating her accordingly.

13. Jean was quite explicit about this: "I give her farlene in her bottle at night time, and she sleeps from half-past ten to six in the morning. See, I was giving her milk at night time, and it wasna strong enough. If I was feeding her at ten, she was getting up at two, and up again at six. But I got her off that middle feed because I put farlene into her bottles. Three teaspoons of farlene in a six ounce bottle. And she takes the whole lot. And it conks her out, because by the time I've finished the bottle, she just gets the wind up and she's like that (i.e. falls over, asleep) over my knee. And I get her into the pram, and she sleeps right through. And so I get a no too bad night's sleep."

14. See Chapter Six.

CHAPTER ELEVEN.

1. See Chapter Six.

2. See Blood R.O. and Wolfe,D.M., 1960, Husbands and Wives, Free Press of Glencoe, Illinois, p.113ff. for a discussion of the reasons why couples have children in traditional societies.

3. Sophie's attitude was rather like the French view of children after the war: Dolto,F., 1970, "French and American Children as seen by a French Child Analyst," in Mead,M. and Wolfenstein,M., Childhood in Contemporary

4. Jessner, L., Weigert, E. and Foy, J.L., 1970, "The Development of Parental Attitudes during Pregnancy," in Anthony, J.E. and Benedek, T., (ed.) Parenthood, Little, Brown and Comp., Boston, 210-44. They argue that women for whom a career or some form of self-actualization means a great deal regard motherhood as a dilemma. This is also a central platform in the Women's Liberation Movement.

5. Caplan, G., 1956, Mental Health Aspects of Social Work in Public Health, University of California Press, California. See Chapter 4: Caplan mentions that for some women the foetus never becomes real, and adds, "This is not uncommon, and it's not a very happy omen usually. You feel worried about the woman who will go right through pregnancy and know she's pregnant, but somehow it doesn't feel right, because afterwards when the baby comes she will not feel a real mother to the child."

6. See Chapter Nine for a discussion of the women's images of their babies.

7. See the previous Chapter. Helen was a good example of a mother who saw herself as a learner and who eagerly sought the advice of others.

8. But see, for example, Bateman, M., 16.3.75., "Big Baby and the Magic Milkman," The Sunday Times, who writes, "The balance of the milk is wrong. Cows' milk was designed for baby cows, not baby humans..."

9. For a review of the literature concerning the relationship between the maternal personality and breast-feeding see Newton, N., 1963, "Emotions of Pregnancy," Clinical Obstetrics and Gynaecology, 6, 639-68. She showed that women who breastfed showed an outgoing and giving attitude towards children. And also, Adams, A.B., ¹⁹⁵⁹ "Choice of Infant Feeding Technique as a Function of Maternal Personality," Journal of Consulting Psychology, 23, 143-6; and Hamilton, E., 1954, Emotional Aspects of Pregnancy, Doctorial dissertation, Columbia University, p.347.

10. See Jacoby A.P., 1969, "Transition to Parenthood: A Reassessment," Journal of Marriage and the Family, 31, p.725: Jacoby found that children frustrate middle class mothers. And Dyer, E.D., 1963, "Parenthood as Crisis," Marriage and Family Living, 25, 196-201: Dyer found that better educated mothers find the adjustment to motherhood more difficult.
11. It is interesting to see this in relation to her body image, which is described in Chapter Six.
12. Work by Dr. Christopher Ounsted at the Park Hospital, Oxford, was reported in The Guardian on 29.4.76 in an article entitled, "Battering clues 'at birth'."

CHAPTER TWELVE.

1. See Cross, E. and Stone, G.P., 1964, "Embarrassment and the Analysis of Role Requirements," American Journal of Sociology, 70, 1-15. They point out that it takes time to prepare the body.
2. LeMasters, E.E., 1957, "Parenthood as Crisis," Marriage and Family Living, 19, 352-55.
3. Dyer, E.D., 1963, "Parenthood as Crisis: A Re-study," Marriage and Family Living, 25, 196-201.
4. Blood, R.O. and Wolfe, D.M., 1960, Husbands and Wives, Free Press of Glencoe, Illinois.
5. Jean's feelings were related to her body image and loss of sexual identity (see Chapter Six.)
6. Rapoport, R. and Rapoport, R., 1968, "New Light on the Honeymoon," in Handel, G. (ed.) The Psychosocial Interior of the Family, Allen and Unwin, Ltd., London, 332-61.
7. Past researchers have also noticed this. For example, see Bibring, G., et al., 1961, "A Study of the Psychological Processes in Pregnancy and

of the Earliest Mother-Child Relationship," Journal of the Psychoanalytic Study of the Child, 16, 9-72.

3. See Blood, R.O. and Wolfe, D.M., op.cit. They suggest that children give parents a purpose in life by providing them with something to work for, plan for and look forward to.

9. Perhaps children have in part taken over from religion here.

CHAPTER FOURTEEN.

1. The National Health Service (Scotland) Act came into force on 1.4.74. Its effects, and its similarities with its English counterpart, are described in Health Services in Britain, 1974, Reference Pamphlet 20, Central Office of Information, H.M.S.O., London.

2. Butler, N.R. and Bonham, D.G., 1963, Perinatal Mortality, Livingstone, Ltd., Edinburgh; and McKinlay, J.B., 1970, "The New Late Comers for Ante-natal Care," British Journal of Preventive Social Medicine, 24, 52-7. McKinlay writes, "With regard to the receipt of ante-natal care, both of these studies show that, as a group, women of low socio-economic status contribute the highest proportion of under-utilizers." (p.52). Much evidence points to the importance of the early stages of pregnancy (e.g. rubella infection is at its most dangerous during the early months, and iron deficiency in early pregnancy seems to have a connection with low birth weight.) See Robertson, J.S. and Carr, G., 1970, "Late Bookers for Ante-natal Care," in McLaughlin, G. and Shegog, R. (ed.) In the Beginning, Oxford University Press, Oxford.

3. The Royal Commission on Medical Education, 1968, Cmd. 3569, H.M.S.O.

4. Freidson, E., 1961, Patients' Views of Medical Practice, Russell Sage Foundation, New York.

5. Barnes, E., 1961, People in Hospital, MacMillan, London.

6. See, for example, Dix, C., 4.9.75., "Do Gynaecologists hate Women?" The Guardian; and Gould, D., 9.11.75., "Away with Women," The Sunday Times
7. Scully, D. and Bart, P., 1973, "A Funny Thing Happened on the Way to the Orifice: Women in Gynaecology Text Books," American Journal of Sociology, 78, 1045-50.
8. See for example, Rachman, J. and Philips, C., 1975, "A new Medical Psychology," New Scientist, 27 February, 518-20.
9. Gillie, O. and Gillie, L., 20.10.74., "The Vital First Hours," Sunday Times, (Weekly Review), 29-30.
10. Burchell, C.R., 1964, "Predelivery Removal of Pubic Hair," Obstetrics and Gynaecology, 24, 272-3.
11. Schofield, M., 1973, The Sexual Behaviour of Young Adults, Allen Lane, London, p.59.
12. The Royal College of Midwives, presenting evidence to a Commons Select Committee on violence in the family, said that girls who were taught about childbirth and parenthood at school would be less susceptible to the stresses which drove some mothers to assault and injure their children. Although mothers who beat their children come from different backgrounds, it seemed that they shared the common factor of stress. This might be caused by financial or marital pressure, but could also stem from ignorance. They emphasized that it was important that a mother's confinement be as stress-free as possible, and maintained that the more a woman knew about her delivery, the more at ease she would be. See "Ignorance and Child Assault," The Guardian, 28.7.76.
13. Bolton's Women's Liberation group have recently produced a booklet for expectant mothers which "tells you exactly what you need to know if you are pregnant and living in that area." For example, it describes precisely what happens during internal examinations and explains how to interpret medical shorthand. Perhaps something similar could be handed out at the

doctor's surgery. See "Sidelines", The Guardian, 14.6.76.

14. Truby King, F., 1924, The Expectant Mother and Baby's First Month, for Parents and Nurses, MacMillan, London.

15. Spock, B., 1948, Baby and Child Care, Duell, New York.

16. Hubert, J., 1974, "Social Factors in Pregnancy and Childbirth," in Richards, M.P.M. (ed.) The Integration of a Child into a Social World, Cambridge University Press, Cambridge.

17. Freidson, E., op.cit., chapter 3.

18. Hubert, J., op.cit., p.33.

19. The women of 'Ashton' also lacked psychological insight into their children. See Dennis, N., Henriques, F. and Slaughter, C., 1956, Coal is Our Life, Tavistock Publications, London.

20. See Chapter Four.

21. Caplan, G., 1964, Principles of Preventive Psychiatry, Tavistock Publications, London.

22. However, some doctors do seem to be able to manage this. See, for example, the doctors described in Klein, H.R., Potter, H.W. and Dyk, R., 1950, Anxiety in Pregnancy and Childbirth, Paul Hoeber, New York.

23. This is one of the recommendations of the Association for the Improvement of Maternity Services (A.I.M.S.)

24. A.I.M.S. also argue that the other advantage of continuity of care would be that the same staff would attend the delivery as gave the patient her ante-natal care.